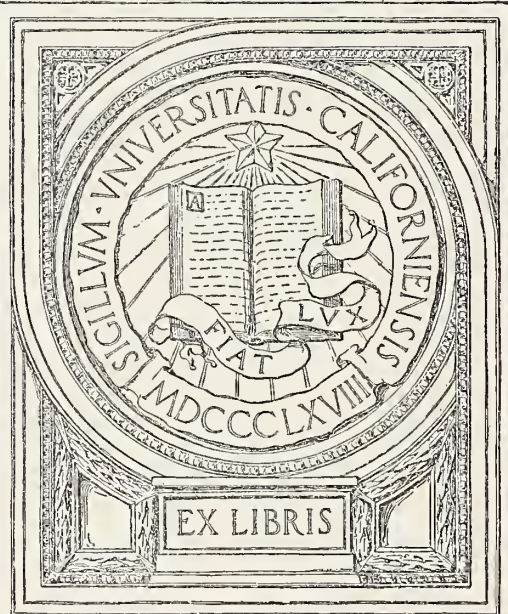


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A Special Report
MENTAL ILLNESS
IN GEORGIA

See Special Section Inside

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Medical Grand Rounds

THROMBOCYTOPENIA, LUPUS ERYTHEMATOSUS DISSEMINATA, AND TUBERCULOSIS

*Transcription of a regularly scheduled weekly conference of the Department
of Medicine, Medical College of Georgia, Augusta, Georgia.*

Staff of the Medical College of Georgia, Augusta

DR. AHLQUIST: Dr. Van Giesen will present our patient this morning.

DR. VAN GIESEN: Our patient is a 40 year old colored female who was admitted here on November 28, 1958 for evaluation of a thrombocytopenia. Her history dates back to 1951 at which time she began having intermittent occurrences of purpuric lesions scattered over the body. In early 1957, she had an episode of severe menstrual bleeding and received pelvic irradiation with cessation of menses.

In February 1957 she noted pedal edema with aching of the feet and consulted her local physician. He noted a butterfly-like rash over the nose and malar eminences and had L. E. preparations done, which were said to be positive. In June 1957 therapy with prednisone was begun. In November because of a persistent cough, chest X-ray examination was done and changes consistent with miliary tuberculosis were seen. Sputum cultures were subsequently positive for mycobacterium tuberculosis. She was hospitalized at Battey State Hospital and remained there for one year, her therapy with streptomycin, isoniazid, and paraminosalicylic acid. On dismissal the streptomycin was discontinued, but she continues on the other drugs.

Physical examination on admission here revealed

a well developed, well nourished colored female who was afebrile. The pulse was 88 per minute and the blood pressure 100/80 mm. Hg. There was increased pigmentation of the skin over the left malar eminence with a surrounding area with some depigmentation, but this was not striking. A few small lymph nodes were palpable in the cervical area, but no other lymphadenopathy was present. The chest was normally developed with normal excursions, but fremitus was decreased in the left base. Cardiac examination was not unusual. The liver and spleen were not palpable. There were no petechiae or purpuric lesions present over the skin or mucous membranes.

Pertinent laboratory data includes a hemoglobin of 12.4 grams per 100 c.c. with a hematocrit of 41 per cent. The white blood count was 3,150 per cu. mm. with 62 polymorphonucleocytes, 21 lymphocytes, 12 monocytes, and two eosinophils. The platelet count was 60,200 (described as increased in size) and the reticulocyte count was 2.4 per cent. Urinalysis showed 1+ albuminuria. Serum electrolytes, BUN, and fasting blood sugar were normal. The serum protein was 8.6 grams per 100 c.c. with an elevated gamma globulin and an A/G ratio of 1.0. The serological test for syphilis was negative.

Bone marrow examination showed hyperplasia

THROMBOCYTOPENIA / Grand Rounds

of all elements. The megakaryocytes were numerous, most of them being intermediate to large and about one third of them actively producing platelets. No evidence of active pulmonary disease was seen on X-ray examination and the electrocardiogram was within normal limits. Her hospital course has been entirely unremarkable. At this time she is awaiting completion of red blood cell survival studies.

DR. AHLQUIST: This case is a good example of the problem that arises when the treatment for one disorder happens to have ill effects on some other disorder. In other words, treatment with prednisone is usually contraindicated in the presence of tuberculosis. I think the best way that we can approach this problem is first to consider prednisone in a general way; then we will ask Dr. Wright to tell us something about the use of this drug in lupus erythematosus or in thrombocytopenia purpura, whichever is the case. Mr. Holloway will tell us about prednisone as a drug.

MR. HOLLOWAY: First a bit about how the steroids work in the so-called collagen diseases. In recent years a lot of attention has been called to these diseases, and recently at one of our sessions, lupus erythematosus was discussed at length by Dr. Sydenstricker. It suffices in this discussion, therefore, to repeat only briefly current concepts or theories on the nature of the disease as pertaining to the site and method of action of the steroids, prednisone in particular, and to briefly mention the incidence of some of the adverse effects to steroids. It is believed that hypersensitivity may be the basic factor in these diseases, and that the mechanism may be that of an antigen-antibody response, which results in fibrinoid connective tissue damage. Recent pathologic studies suggest that fibrinoid connective tissue damage is the result of precipitation of abnormal proteins within the amorphous ground substance. These abnormal proteins apparently circulate within the plasma, and reach the ground substance by transudation. In disseminated lupus erythematosus, the vascular system and the mesothelial and synovial membranes are primarily affected. Specific antigens are not known at present, but are assumed to be diverse, including bacterial and non-bacterial substances. It has been observed that the corticosteroids often cause remission of symptoms in these diseases, and this has been interpreted by some as a substantiation of the theory of antigen-antibody response.

It is known that these steroids inhibit cellular mitosis, and have a marked effect on lymphoid tissue, producing not only diminished production but also

dissolution of lymphocytes. It has been observed in rabbits that mitosis throughout the reticuloendothelial system is depressed, and that the allergic inflammatory response is therefore diminished; however, this has not been verified in humans. It is not clear whether the antigen-antibody responses are blocked, or whether the tissue response is merely held in check. At any rate the use of steroids does not offer any cure, but rather a simple palliative treatment, and temporary suppression of symptoms. When their use is discontinued, symptoms may return within a few days or weeks. In approximately one-fourth of the patients symptoms may not return for several months, but this cannot necessarily be attributed to the medication. The response to therapy is rapid, and may become evident within a few hours; however, not all manifestations of lupus erythematosus are affected. Fever, tachycardia, arthralgia, cutaneous and mucosal lesions and serositis may subside within a few days. Serum albumin may rise toward normal, and gamma globulin may decrease. The hematological picture varies, but in most cases a reticulocytosis occurs, and the anemia disappears. A mild lymphocytosis is sometimes seen. Cardiac and renal features respond very poorly or not at all.

As is very often the case in drug therapy we don't get something for nothing, and I would like to mention briefly one or two of the undesirable side effects. The steroids in many individuals appear to be diabetogenic; in others this is not the case. In those that are affected, there is slight hyperglycemia, mild glycosuria, and a change in the glucose tolerance curve toward the diabetic type. Usually these effects disappear if therapy is discontinued. In those patients who have developed frank diabetes mellitus, it is believed that there was a pre-existing inadequate islet cell reserve, and in several reported cases, family histories of diabetes mellitus were elicited. The pre-existence of diabetes mellitus implies caution in the use of corticosteroids, but is not an absolute contraindication, since adequate doses of insulin will control the situation. The steroids are not diabetogenic in the sense that a permanent impairment of carbohydrate metabolism always follows their use. Another adverse side effect is the retention of sodium and subsequently the development of edema. In certain cases with pre-existing cardiac and renal involvement, this may already be present. If this happens, the patient should be put on a low salt diet and on diuretics. Some of the other adverse effects are increased potassium excretion, hypercorticism, virilism, hirsutism, poor wound healing, and peptic ulcer.

Prednisone by weight is approximately three to

five times more potent than cortisone. Allegedly there are fewer side effects and better therapeutic results. There are also several newer synthetic steroids. One of the contraindications for the use of steroids as has been pointed out, is active tuberculosis. In this patient it is something of a paradox that she has diseases for which steroids are both indicated and contraindicated; however, clinical evidence indicates that the tuberculosis is arrested. During the treatment for active tuberculosis, steroids were not administered. She is now on PAS and isoniazid and this therapy will continue for a period of one year upon the recommendation of physicians at Battey State Hospital. Since the tuberculosis is no longer considered active, it is felt that steroid therapy could be administered for the thrombocytopenia. With proper precautions and frequent observations, the steroid therapy in this patient should be safe.

DR. AHLQUIST: We will ask Dr. Wright to comment on the original difficulty in this patient, thrombocytopenia purpura, how this is related to lupus, and the effect of any of the various treatments.

DR. WRIGHT: In going back over the patient, and putting down the date that the various symptoms appeared, purpura started in 1951, uterine bleeding occurred in 1957 and then she received pelvic irradiation to bring about cessation of menses. Also in the early part of 1957 she developed a clinical syndrome which was compatible with lupus erythematosus disseminatus. The physician that saw her at that time did an L. E. preparation, and he said that the result of this L. E. preparation was compatible with that of disseminated lupus. Repeatedly, other L. E. preparations have been negative, so we really have to be a little skeptical of this being lupus erythematosus disseminatus. She is here to determine (1) whether she does have disseminated lupus, (2) whether this means additional therapy, and (3) what should be done about the thrombocytopenia. Her platelets now are running about 70,000 per cu. mm. which is considerably more than they have been during last year. Now, is this thrombocytopenia secondary to a generalized systemic disease such as lupus, or is it idiopathic? We are working on the assumption that perhaps this thrombocytopenia is secondary to a generalized systemic disease (like lupus) involving the spleen and causing a so-called hypersplenic thrombocytopenic purpura. Examination of her bone marrow now shows that the megakaryocytes are numerically increased and about one out of every three is in active platelet production. This is compatible with hypersplenic thrombocytopenia purpura. I think that the 70,000 platelet level does carry a potential danger to this woman. We normally consider about 60,000 as the critical level below which

one may get bleeding. In this patient it frequently has gone below this level. We have two means of helping this patient: (1) steroids and/or (2) splenectomy. I think I would favor a direct approach with splenectomy favored at this time.

DR. AHLQUIST: We should hear about the other half of this case and will ask Dr. Carter if he will make some comments regarding the relationship between the adrenal cortical hormones and tuberculosis, whether they are contraindicated and whether they have any value in treatment of tuberculosis.

DR. CARTER: I think in this particular patient, we first have the problem of the precipitation of an infectious disease process in a patient on steroids. Also, the patient represents the problem of the control of an infectious disease process in a patient that is receiving steroids. We're often faced with the problem of what to do about drug therapy in a patient receiving steroids that has a history of tuberculosis in the past. If it is known that a patient is to receive protracted steroid therapy antituberculous therapy is certainly indicated. Then you have to consider the patient that has only a positive tuberculin skin test in whom you want to use steroid therapy. If the therapy is to be prolonged, and if there is any evidence whatsoever that a previous pulmonary lesion, bone lesion, renal lesion, or any evidence of tuberculosis by history or otherwise, it is suggested that concomitant antimicrobial therapy is indicated. We know that steroids do result in undesirable side effects in infectious disease, such as diminished capillary permeability, diminished inflammatory response, and diminished resistance. In patients receiving steroids, this would lead us to think that probably control, if possible, of the infectious disease process would be desirable and I think in this patient it is also obvious that once the diagnosis of tuberculosis was established, administration of antituberculous drugs was effective in controlling the disease process. In almost any infectious disease process, steroids may well have a deleterious effect, but I think this is more outstanding in patients where you have staphylococcal infections, genitourinary tract infections (especially gram negative infections), and tuberculosis and fungal infections. So it is in these situations that we find it desirable to administer an antimicrobial that will control the infectious disease process. Many people in discussing the matter of steroids in tuberculosis feel that adequate control studies have not been presented. As to the value of steroids in patients critically ill with a tuberculous infection, it might well be said that the most outstanding reason for using steroids in such a patient is that many clinical impressions have been gained that these patients do

THROMBOCYTOPENIA / Grand Rounds

better. However, observations of some patients critically ill with disseminated tuberculosis treated with INH and PAS alone indicate that they did as well as many of the patients that have shown such dramatic responses with the use of steroids.

DR. AHLQUIST: We should finish this presentation by asking Mr. Holloway to tell us briefly about some of the potential side effects of the three drugs that were used for the treatment of tuberculosis.

MR. HOLLOWAY: First let me say that I don't think that this patient has had any of the adverse effects that we do see with these drugs. There was some suggestion of ataxia, but in giving the history, she said that she had had this for many years. I don't think it is very definite. She was given streptomycin, PAS (aminosalicylic acid) and isoniazid during her active treatment at Battey and she is now being continued, as we have said, on isoniazid and PAS.

The principal side effect of streptomycin is damage to the eighth nerve. It occurs on occasion in connection with prolonged treatment with streptomycin and it has been suggested that patients should have an adequate evaluation of auditory function prior to starting therapy. There seems to be in some patients a greater derangement of vestibular function rather than auditory function. The disturbance of vestibular function is that commonly seen with any type of damage to that organ, ataxia being the most prominent feature. These patients recover in most instances when the drug is discontinued, but some do have permanent residual damage for which there is no known treatment. With disturbance of auditory function, the first symptom usually being tinnitus, the drug should be immediately discontinued. There is some evidence that the size of the dose determines the incidence of damage, rather than duration of therapy, and therefore the dose should be the minimum dose consistent with the requirement.

The principal toxic effects of PAS are on the gastrointestinal tract. Administered orally, you get local irritation resulting in anorexia, nausea and vomiting, and diarrhea. These symptoms can be alleviated somewhat by the administration of aluminum hydroxide gel. The sodium salt of the drug is said to be somewhat less irritating than the free acid. There have been some hypersensitivity reactions reported, such as pruritic dermatitis and drug fever. It has also been observed that some patients will develop a leucopenia but there have been no cases reported of agranulocytosis. There may also be some degree of renal damage from the use of PAS, and therefore caution should be used in administering the drug in the presence of renal disease. As in the case of salicylic acid, PAS also slightly depresses prothrombin activity in the liver, but the decrease in the prothrombin in circulation is not of clinical importance in the average patient.

Isoniazid can produce peripheral neuropathies such as hyperesthesia that can be prevented by the administration of pyridoxine. Sensory changes of the "stocking and glove" type have been reported, as has the occurrence of Raynaud's phenomenon. Isoniazid also produces a type of central nervous system stimulation, and therefore, should be used with caution in the presence of epilepsy. There have also been reports of toxic effects on the bone marrow, liver and kidney but there is no universal agreement that these are direct drug effects.

DR. AHLQUIST: We've just about used up the time, so I think we can state we have here a patient with possible lupus, definite thrombocytopenia, and tuberculosis, with the exact relationship of the three not being firmly established, and with Dr. Wright recommending splenectomy as further treatment.

Addendum

A therapeutic trial with steroids, adequately covered with the anti-tuberculous drugs, failed to correct the thrombocytopenia. Splenectomy was done and was successful.

JAMES E. SKRINE VS. JOHN MOONEY, JR.

THE FOREGOING MATTER coming on regularly to be heard before the State Board of Medical Examiners, after due notice, in Room 224, State Capitol, Atlanta, Georgia, the respondent, Dr. John Mooney, Jr. was present. After hearing the testimony and examining the evidence submitted, the Board unanimously determined that good and sufficient evidence had been submitted to revoke the license to practice medicine of the said Dr. John Mooney, Jr.

Now, therefore, it is considered, ordered and adjudged that the license of Dr. John Mooney, Jr. to

practice medicine in Georgia, be, and the same is hereby revoked under and by virtue of the authority vested in said Board by the laws of Georgia. It is further ordered that any Clerk of the Superior Court in whose office said license is recorded, is hereby ordered and directed to cancel the record of said license by entering upon the face thereof a certified copy of this order.

This 4th Day of December 1959.

State Board of Medical Examiners of Georgia.
By: L. W. Willis, M.D.,
President.

PROBLEMS ENCOUNTERED IN SETTING UP A RADIOISOTOPE LABORATORY

This paper gives a practical appraisal of the difficulties encountered in the setting up of this valuable facility in a general hospital.

John R. McLaren, M.D., *Atlanta*

THE PROBLEMS ENCOUNTERED IN establishing a radioisotope laboratory may be broadly divided into those which are common to all new similar enterprises and into those specifically related to radioisotopes. Most of you became aware of the problems in the first group when you left your training program and established your own department and/or office. For this reason I will say very little about this group; however, in deference to our earlier teachers and professors a few comments should be made. Most departments offering training have been established for some time, and it is not difficult for the trainee to gain the impression that techniques (both diagnostic and therapeutic) are spontaneous in birth and of ideal parentage. One also gains the impression that administrative problems are a rarity and that they really are not much of a problem at all. These illusions, of course, have quite a short half-life and one is not in practice long until he wonders why he had been so effectively shielded from the responsibilities of administration, supervision, and budgeting.

The problems more related to radioisotopes may be categorized as follows:

1. Preceptorship of physician
2. Obtaining A.E.C. license
3. Space
4. Instrumentation

5. Personnel
6. Training programs
7. Procedures
8. Waste disposal
9. Records
10. Middle man

Preceptorship for Physician

The physician heading a radioisotope laboratory should have basic training providing:

1. Principles and practices of radiological health safety.
2. Radioactivity measurement, standardization and monitoring techniques and instruments.
3. Mathematics and calculations basic to the use and measurement of radioactivity.
4. Biological effects of radiation.
5. Actual use of byproduct material in the types and quantities for which application is being made, or equivalent experience.

He should also have active clinical participation consisting of:

1. Examination of patients to determine suitability for radioisotope diagnosis and/or treatment and recommendations on dosage to be prescribed.
2. Collaboration in calibration and administration of dosages including related measurements and plotting of data.
3. Active period of training and experience of sufficient duration to permit follow-up of

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From the Department of Radiology, Emory University School of Medicine, Atlanta, Georgia.

patients through treatment and post-treatment period including re-evaluation as to effectiveness and complications.

- 4. Study and discussion of case histories to establish most efficacious diagnostic and/or therapeutic techniques for the proposed use.

The basic training unit consists of 30 hours in a formal program with active participation in the diagnosing of ten thyroid cases. This qualifies one to perform the various thyroid function tests. One may qualify for the treatment of hyperthyroidism by adding to the above the active participation in treatment of ten patients with this disease. Certification for other diagnostic studies may in general be obtained by participation in three similar tests. One may qualify in the treatment of malignancies either by his specialty or by actively participating in the treatment of a number of patients, usually three or six.

Obtaining A.E.C. License

I believe we all realize that the A.E.C. is one of our many present day bureaucracies. In all fairness I believe I should point out that they have realized this since birth and have made an honest effort to keep all their rules and regulations purposeful. Nevertheless, when one attempts to fill out the necessary forms in triplicate presenting this bureau with preceptorship, dosage schedule, instrument list, waste disposal, and references to substantiate uses of various radioisotopes he is certain to doubt the need for much of this information. Many problems will arise and I know of no way to predict your questions and give answers at this time. I would suggest that you set aside one-half day to fill out these forms. These may be obtained from the A.E.C. and from most detailers of radioisotopes. Prior reading of the Federal Registry, Volume 22, No. 19,

Title 10 Atomic Energy and the Atomic Energy Commission booklet entitled Medical Use of Radioisotopes, Recommendations and Requirement by the Atomic Energy Commission, No. RC 12, will be quite helpful. Both of these may be obtained from the Isotopes Extension, Division of Licensing and Regulation, U.S. Atomic Energy Commission, Washington, D. C.

Space

Space requirements will vary widely depending upon the types and number of procedures to be performed. Generally the space needs may be broken down into the hot laboratory, counting area, and office space. In the smallest laboratories doing only several procedures a week and these primarily limited to uptakes, all these divisions may be combined into one area of approximately 150 to 200 square feet. Some idea of the necessary space can be gained from Table I in which the space and instrumentations are correlated with the procedures to be performed. Provisions should be made in the hot laboratory for a work bench, fume hood, sink, storage facilities, and a waste container. Where possible these surfaces should be of a hard, non-porous material. Stainless steel is ideal for sinks and working surfaces on fume hoods and work benches. Asphalt tile and tile are ideal for flooring and lower wall surfaces respectively. Where wooden or porous surfaces are exposed they should be covered with three coats of good paint. Strip coat paint makes an ideal final covering because in case of spillage, the surface can be decontaminated by simply stripping large sheets of the final coat. It should be mentioned that if you are to use radioisotopes in your private office, hospital facilities should be available in case such facilities are needed or desired.

Instrumentation

Reference may be made to Table I for correlation of the instrumentation required for the various procedures you may desire to perform. It will be noted

TABLE I

PROCEDURES	SPACE (SQ. FT.)		INSTRUMENTATION
	HOT LAB	CTN.	
Therapy (Excluding Thyroid)	100		Beta-Gamma Survey Meter Cost with Accessories . . . \$ 400
Uptakes (May include Schilling's, etc.)	150	200	Scintillation Probe 1"x1" Flat Field Collimator Scaler with Timer \$2000
Above plus Blood Vol. RBC, Mass, etc.	150	300	Scintillation Well Counter Additional \$1000
Plus Physiological Clearances	150	500	Count Rate Meter \$ 500 May Need Pair For Renal Studies Plus Second Probe \$1900
Area Scanning		300	Scanner Min. \$5000

that Table I includes only those instruments used in measuring the uptake of radioactivity by various organs or the radioactivity in various specimens from the patient. In larger laboratories or for special purposes one may desire to assay the radioisotopes received from the pharmaceutical houses and for this purpose Geiger-Mueller or scintillation detectors, or ion chambers will be desired.

It is also necessary to have instruments to survey work areas weekly to be sure that radiation levels are not above tolerance. This is one point on which the A.E.C. is specific and states that such an instrument must be present and in working condition at all times. Although this requirement does not state that the laboratory must have two such instruments available, purchasing a pair of instruments is one way of solving this problem. A number of lead bricks will be necessary for shielding purposes. Film badges are adequate for personnel monitoring, however, if one wishes to check acute exposures during any one procedure, ion chambers should be available. In addition to the above, general laboratory equipment will be needed such as remote pipetter, pipette washer, and possibly a Waring blender, centrifuge, and refrigerator. A shielded therapy cup, shielded syringes, and remote handling tongs may also be desired.

Personnel

One of the major problems will be the hiring of a radioisotope technician. You may inquire of the various radioisotope detail and instrument men, but I predict that this will be to no avail. I would suggest that the easiest way to solve this problem is to train either a laboratory technician or an X-ray technician who is interested in radioisotopes and who has a good basic knowledge of mathematics by teaching them one procedure at a time or sending them to one of the centers for three or four months. I would like to emphasize that the two requirements are mandatory, that is, individuals should have a genuine interest in isotopes and have a good basic knowledge of mathematics. If you have an institutional license the services of an individual experienced in the assay of byproduct materials and protection against ionizing radiation will be required and this individual must be a member of the radioisotope committee.

Training

You will learn, or you probably have already learned in diagnostic X-ray, that the nursing service is afraid of radiation because of the campaign in the lay press. The novelty of radioisotopes will make this even more a problem and some type of training

program will be necessary to allay their fear of nursing the patients who have received radioisotopes.

A brochure describing the more common procedures and pointing out the extremely low dosages used in diagnostic procedures as well as demonstrating safety procedures undertaken when patients receive therapeutic doses is of value. Pamphlets are available from the A.E.C. and various detailers of radioisotopes for education of nurses.

It will also be necessary to train nurses in the collection of various biological specimens, particularly stool specimens. To illustrate the unpredictability of the problems in establishing an isotope laboratory, I would like to tell a short story about stool collections. Our lab had been operating for approximately four months and had "solved" most problems. Suddenly for about three days we were unable to obtain any stool specimens on a patient even though the nurse in charge was certain these specimens had been collected and sent to the laboratory. With some detective work we were able to learn that they had indeed been sent to the laboratory, but to the main laboratory and not the radioisotope laboratory. I know no way of solving this problem unless you wish to call your particular laboratory the radioisotope den, radioisotope beehive, or some other appropriate word.

It will also be necessary for you to establish a safety training program for your radioisotope technician and to train him in the use of various safety devices.

Procedures

It is difficult to predict what type of procedures your lab will perform. As a group of radiologists most of you would prefer to do some type of therapeutic procedure with radioisotopes. As you will see in Table I, therapy exclusive of thyroid therapy can be performed with a minimum investment. However, unfortunately, these procedures also require a maximum expense for the radioisotopes and these procedures are seldom done at a profit. Thyroid uptakes will be a must. The demand for Schilling test is increasing. Fat absorption tests are similar to the Schilling test both as to theory and technique, and these may be performed with a minimal amount of equipment. Blood volumes are finding increasing demand and may be done by simply adding a deep well counter. With this equipment red cell mass, red cell survival, and red cell deposition may be determined. The numbers of these various special procedures performed will be a function of the specialty of your referring clientele. If you are to outfit a "Cadillac" laboratory, you may wish to scan with respect to time and do physiological clearance rates and also do area scanning. Both of these require

RADIOISOTOPE LABORATORY / McLaren

moderately large outlays of cash and will probably not be profitable.

Waste Disposal

Unless one plans to do animal work, waste disposal will not be a problem. Nearly all of this may be disposed into sewage without danger of exceeding safe limits. If solid specimens are collected, one may be presented with a problem because incineration is not an ideal method of disposing of radioisotopes. A garbage disposal unit connected directly to the sewer system which would make solids dispersible will solve this problem and permit disposal of any specimens collected in the routine laboratory via sewage. One should refer to the Federal Registry, volume 22, No. 19 for the limits of radioactivity of various radioisotopes which may be disposed into sewage. You may not exceed one curie per year.

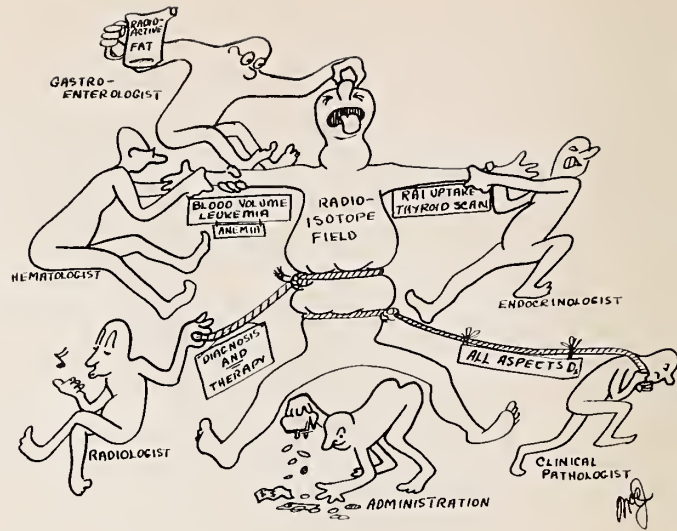
Records

After obtaining the A.E.C. license, the physician is constantly reminded of his association with a bureaucracy by the necessity of maintaining records. But this is largely for radiation safety purposes and merely entails accounting for shipments and disposal of radioisotopes as well as radiation levels of work surfaces and exposures of personnel. Records should be kept of:

1. Incoming shipments
2. Personnel exposures
3. Survey of areas (weekly)
4. Disposals
5. Patient dosages

Middle Man

The problems of the middle man are best illustrated by the enclosed cartoon drawn by Dr. McClaren Johnson, Jr., a member of our house staff. I think most of these are self-explanatory, however, it should be pointed out that these problems will exist whether a radiologist or some other specialist



is head of the radioisotope laboratory. Relevant to the administrators desire to collect a few dollars I would like to give just a few figures that you may combine with the anticipated outlay of Table I and other basic equipment given under instrumentation so that you may arrive at an estimate as to how much a radioisotope laboratory will cost your hospital or department and the possibility of operating at a profit. The average charge per procedure in the Atlanta area is approximately \$12.00. In our laboratory, in which we are at the present time performing approximately 90 procedures per month, the cost of expendable materials including radioisotopes is just under \$100.00. The salary of a radioisotope technician will be approximately \$300.00. To these figures you may add your fee for rent, professional services and arrive at a rough estimate of your net gain or loss for operating a radioisotope laboratory. This figure includes only monetary values. One must also consider such intangibles as service to the patient, and referring doctors, and the challenge of broadening ones scope and field of interest.

Emory University School of Medicine

POSITIVE AMA LEGISLATION

ONE FREQUENTLY HEARS that AMA does not have a "positive" program and that we are "against" everything. To help counteract these rumors, a list has been made of some of the important health legislative issues which AMA has supported. These are as follows:

- 1906 Food and Drug Act
- 1914 Harrison Narcotics Act
- 1924 Caustic Poisons Act
- 1934 Modernization of Food and Drug Act
- 1946 Hill-Burton Hospital Construction Act

- 1950 Doctor Draft Act
- 1953 Creation of Department of Health, Education and Welfare
- 1954 Addition of Four Categories to Hill-Burton Construction Act
- 1957 Medicare
- 1958 White House Conference on Aging
- 1959 Mortgage Guarantees for Construction of Nursing Homes (FHA)
- 1959 Federal Employees Health Insurance Act.

FIBULAR TRANSPLANT FOR TIBIAL DEFECT

This procedure was carried out with no significant shortening of the leg.

W. P. Warner, Jr., M.D.; Robert T. Willingham, Jr., M.D., and

Jonathan S. Swift, M.D., *Atlanta*

FRACTURES OF THE TIBIA with established non-union are difficult to treat. The problem is magnified greatly when there is also infection and loss of tibial substance. Faced with this situation one has several alternatives of treatment. We have used fibular transplant in conjunction with massive iliac bone grafts in the case reported here. Other alternatives are: by shortening the tibia to approximate the fragments with its resultant leg length discrepancy and attendant problems; massive bone grafts to bridge the defect without the internal fixation of a fibular synostosis; or below knee amputation.

Fibular transplant for loss of substance of the tibia was first described by Hahn in 1884; the first published report in this country was by Huntington in 1905, who used the procedure in a case of osteomyelitis in a five year old child. The child had sequestered almost the entire tibial shaft. Huntington transferred the fibula with excellent results. There was tremendous hypertrophy of the fibula, so that it effectively replaced the destroyed tibia.

A similar case was reported in 1907 by Stone with a good result.

Campbell in 1919 first described transplant of the fibula as an adjunct to free bone graft in tibial deficiency. He described three cases in which there was loss of substance of the tibia. He used a two stage operation—first stage, the fibula was transplanted and at a later date a massive iliac bone graft was used to bridge the defect. The following case was done using Campbell's technique:

The patient was a 22 year old white female, first seen on October 11, 1954. She had sustained a compound fracture of the right tibia and fibula, middle third, on May 25, 1952, two years prior to our first examination. The original surgery of open reduction with internal fixation had been complicated by osteomyelitis and on two subsequent operations the metal had been removed and skin graft was done.

The first examination in our office was October 11, 1954; there was a draining sinus over the middle third of the tibia with excessive adherent scar tissue (Figure 1). There was clinical motion at the fracture site. X-rays showed non-union of the tibia with the presence of two sequestrums. Patient was fitted with an ischial weight-bearing brace and instructed on sterile technique for the daily dressing to the draining sinus tract.

On January 7, 1955, the patient was operated upon at Piedmont Hospital. A saucerization, sequestrectomy and excision of scar tissue was performed. The wound was packed open. Wet dressings were started and the wound was allowed to granulate in. By March 22, the wound had healed and drainage had ceased. Excision of the adherent scar over the tibia and a secondary closure was done a few weeks later.

Patient was then ambulatory in her brace. This had a ring lock-knee and she had retained her knee motions in the brace. She was next seen in the office on September 21, 1955. The wound remained well healed and dry (Figure 2). X-rays showed a large defect in the tibia but no evidence of osteomyelitis and no sequestrum. Two weeks later the fibula

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Figure 1.

was transplanted into the proximal and distal fragments of the tibia. The neck of the fibula was grafted into the tibia just below the articular surface of the lateral tibial plateau. The distal fibula was cut just above the lateral malleolus and fixed to the distal tibia and with screw. Long leg plaster was applied, which the patient wore for three months. She was then put back into her ischial weight-bearing brace —by April, 1956 the fibula had united with the proximal and distal tibial fragments, giving stability to the leg (Figure 3).

On April 20, 1956, 18 months after she was

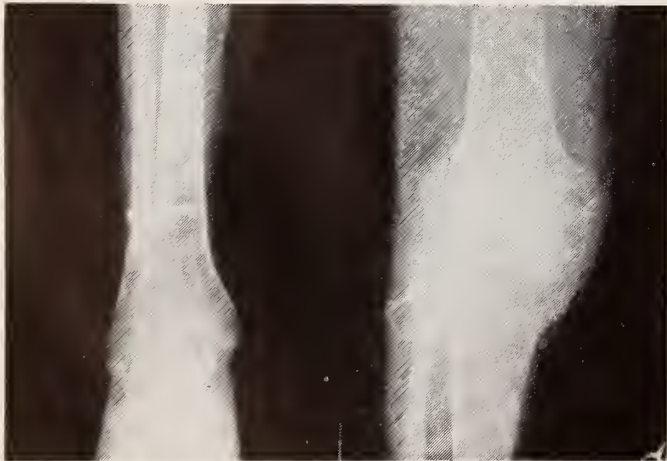


Figure 3.



Figure 2.

first seen in our office, massive iliac graft was used to bridge the tibial defect. Postoperatively the



Figure 4.



Figure 5.

wound healed primarily with no evidence of infection. Eight months later there was X-ray and clinical



Figure 7.



Figure 6.

evidence of union (Figure 4). She was allowed full weight bearing in a long leg brace. In June, 1957, 14 months after the massive iliac graft and 21 months after the fibular transplant, patient was allowed to walk without external support. At that time she had clinical and X-ray evidence of solid healing at the fracture site. She quickly resumed normal daily activity. When last seen in our office, May 1959, she was walking with only a slight limp. She had no pain. The tibia was solidly united both clinically and by X-ray. There was $\frac{1}{2}$ inch shortening. (Figures 5, 6, and 7).

Conclusion

We believe that this case illustrates the soundness of this surgical procedure and its usefulness in cases where there is large tibial defect, particularly when there is infection at the tibial fracture site. The initial procedure of fibular transplant can be done while the infection is being cleared up. Transplant of the fibula can be used as a definitive treatment as in the case of Huntington or either in conjunction with the massive iliac bone graft to the tibia. Transplanting the fibula alone without obtaining the tibial union leaves some instability and usually requires brace for ambulation. In children, however, hypertrophy of the fibula often compensates for

FIBULAR TRANSPLANT / Warner

the absent tibia and as reported by Huntington and Stone give a brace-free stable leg.

1938 Peachtree Road, N.W.

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JOB CALDWELL PATTERSON

NEWS OF THE DEATH of Job Caldwell Patterson, more affectionately known as "J.C.", Sunday evening, November 8, brought sadness to his countless friends in Cuthbert and throughout the state. Dr. Patterson, Chief-of-Staff, of Patterson Hospital, died suddenly of a heart attack at his home on Lumpkin Street.

Born in Lumpkin, Georgia, he was the son of the late John T. Patterson and Elizabeth Humber Patterson, of Stewart County, Georgia.

He received his education in the Stewart County Public Schools and Atlanta College of Physicians and Surgeons, now Emory University Medical School, from which he received the degree of Doctor of Medicine in 1913. Following his graduation he served as Intern and Resident at Grady Memorial Hospital.

He served as a Major in World War I, acting as Director of Field Hospitals of the 31st Division in France.

After the Armistice he studied at the D'Aix Marseilles Medical School in Marseilles, France, and he did post-graduate work at the leading clinics throughout the United States, including the Mayo Clinic, Lahey Clinic and Ochsner Clinic.

He became associated with the late Dr. Frederick Davis Patterson, Sr., founder of Patterson Hospital, in 1919, becoming head of the institution on the death of Dr. Frederick Davis Patterson, Sr., in 1930.

Dr. Patterson had served as a member of the City Council of Cuthbert, as President of the Cuthbert Rotary Club, as President of the Randolph-Terrell Medical Society, the Third District Medical Society, the Georgia Chapter of the American College of Surgeons, and the Medical Association of Georgia. At the time of his death he was a Fellow in the American College of Surgeons and the International College of Surgeons. He was Randolph County Physician and was a member of the Randolph County Board of Health, was serving on the Board of Directors of Blue Shield of Georgia, was a Trustee of Andrew College, a Director of the Citizens' Bank of Cuthbert, and the Randolph County Federal Savings & Loan Association. He was local sur-

geon for the Central of Georgia Railroad Company and the Seaboard Air Line Railway Company, and he had very recently been elected President of the Association of Seaboard Air Line Railway Surgeons. He was a Mason, a Shriner, a member of the American Legion, the Phi Chi Medical Fraternity, and the Cuthbert Rotary Club.

He did honor to his profession, serving it faithfully. He was a renowned surgeon, and through his unusual ability as a physician and surgeon, his keen interest in and promotion of education, his untiring energy, his fortitude of character, his love for humanity, and his unselfishness he won the esteem of the county in which he lived and the state which he served. His keen sense of humor and magnetic personality endeared him to all with whom he came in contact.

His home life was ideal, always enjoying the companionship of his wife, his daughter, and his grandchildren. He contributed immeasurably toward their happiness and comfort.

Dr. Patterson was a well rounded man, a man in every sense of the word, this being portrayed by his contribution to mankind. Not only did he contribute much in a professional way, but he contributed much in a social and personal way. He was an avid golfer and loved to hunt and fish. He believed not only in hard work but in some recreation, and he felt that a combination of the two made for a fuller life. He was an ideal companion in all walks of life. Such men are rare, and the loss of such a man is tragic to those he left behind.

Dr. Patterson is survived by his wife, Mrs. Marie King Patterson; one daughter, Mrs. Robert Green Puckett; and three grandchildren, Patricia Puckett, William Patterson Puckett, and Elizabeth Ann Puckett, of Shellman, Georgia; one sister, Mrs. Sam Gatewood, of Richland; one brother, C. Humber Patterson, of Atlanta; and his step-mother, Mrs. John T. Patterson, of Lumpkin, Georgia.

EPITHELIAL CANCERS OF THE PALATINE TONSIL

The great majority of patients can be treated by means of external supervoltage radiation only.

John F. Dillon, M.D., *Augusta*

THE PURPOSE OF THIS paper is to call attention to a truly significant contribution to the oncologic literature which appeared in 1956. In that year, A. Ennuyer and J. P. Bataini published a monograph entitled "Les Tumeurs de l'Amygdale et de la Region Velopalatine." Included in this work are the statistics compiled at the Foundation Curie in Paris for the years 1919 to 1948. These prodigious investigators reviewed in detail the data concerning more than 800 patients treated for malignant tumors of the tonsil and tonsillar region.

In this discussion, the term epithelial cancers includes squamous cell carcinoma of the tonsil and lymphoepithelioma of the tonsil. It excludes lymphosarcoma of the tonsil.

The epithelial cancers of the palatine tonsil are much more frequently encountered than are lymphosarcomas of the tonsil. It has been estimated by Ennuyer and Bataini that one is likely to see four epithelial cancers of the tonsil for every lymphosarcoma seen. The epithelial carcinomas of the tonsil comprise approximately 1.5 per cent of all malignant tumors. Ninety per cent of these tumors occur in males. This exaggerated predominance in favor of males is not noted in the lymphosarcomas. Only 60 per cent of patients with lymphosarcoma of the tonsil will be male; the remaining 40 per cent female.

There are several distinct tumors which originate in the vicinity of the palatine tonsil, which, strictly speaking, are not tumors of the palatine tonsil. These tumors, because of their proximity to the tonsil, are often considered to be of tonsillar origin. The tumors which are most likely to be confused with tumors of the tonsil are: (1) squamous cell carcinoma of the soft palate adjacent to the tonsil; (2) squamous cell carcinoma of the retro-molar trigone; (3) squamous cell carcinoma of the foot of the

anterior tonsillar pillar; and (4) squamous cell carcinomas of the glosso-palatine sulcus. These tumors are distinct clinical entities. They have different malignant potentials, different natural histories, different responses to radiation therapy, and different prognoses.

Squamous cell carcinomas of the soft palate constitute a well-known clinical entity. Usually, they can be recognized as discreet tumors not involving the tonsil. However, when these neoplasms originate adjacent to the apex of the tonsillar fossa, there may be some confusion as to the exact site of origin.

Squamous carcinomas of the retro-molar trigone originate in the mucosa behind the upper and lower third molar teeth and between the buccal mucosa and the anterior tonsillar pillar. Early lesions of this type can readily be distinguished from carcinomas of the tonsil. However, when these tumors are extensive, they may involve the tonsil and the pterygo maxillary fossa. In general, these tumors of the retro-molar trigone have a worse prognosis than tumors of the palatine tonsil.

Squamous cell carcinomas originating at the foot of the anterior tonsillar pillar are usually moderately well differentiated. They present lymph nodes at a lesser frequency than do epithelial cancers of the tonsil. In practice, they are treated by the radiologist under the assumption that they are epithelial tumors of the tonsil. They are cured less frequently than are epithelial tumors of the tonsil.

Squamous cell carcinomas of the glosso-palatine sulcus originate, as their name implies, in the sulcus between the tongue and palate, immediately subjacent to the tonsil. In general, these tumors are less responsive to radiation therapy than are tumors of the tonsil.

Epithelial cancers of the tonsil by natural growth may involve many of the surrounding structures. It

PALATINE TONSIL / Dillon

is only rarely that these tumors are discovered involving the tonsil only. Ennuyer and Bataini found this limited localization of the disease in only six per cent of their cases. The tumor may spread from its site of origin in the tonsil to the anterior tonsillar pillar, to the posterior tonsillar pillar, to both tonsillar pillars, to the soft palate, to the retro-molar trigone and buccal mucosa, to the anterior two-thirds of the tongue, to the base of the tongue, to the lateral wall of the oral pharynx and to the lateral wall of the hypopharynx.

The majority of these tumors, when first seen, involve the anterior or posterior pillar, or both, as well as the tonsil. Slightly more than one-half of these patients will have involvement of the soft palate. About one-half will have invasion of the tongue. One patient in five will have involvement of the lateral wall of the oral pharynx. The other possible extensions of this tumor are only rarely seen. It is interesting to note the extreme frequency with which tumors of the tonsil will invade the tongue. This fact is in contrast with the relatively small number of patients who have primary lesions in the tongue which extend to the tonsil. It is almost unknown for an epithelial cancer of the tongue to invade by direct extension the tonsillar area. On the other hand, it is frequently noted that a patient with a relatively small epithelial cancer of the tonsil will have a massive invasion of the tongue.

Symptoms of Epithelial Cancers

The presenting symptoms (Ennuyer and Bataini) of epithelial cancers of the tonsil, in order of their frequency, are listed below:

1. Discomfort in the pharynx—68 per cent
2. Cervical adenopathy—18 per cent
3. Ear aches and discomfort in the pharynx—seven per cent
4. Ear ache—three per cent
5. Cervical adenopathy and discomfort in the pharynx—two per cent
6. Others—two per cent

It is frequently noted that individuals with carcinomas of the tonsil seek help because of either the feeling of discomfort in the pharynx or cervical lymph nodes.

The examination of the patient should consist of a thorough inspection of the oral cavity, the nasopharynx, oropharynx, and hypopharynx. Palpation of the soft palate, tonsillar fossa, tongue, and floor of mouth should not be omitted. If the palpation of the structures in the oral cavity causes pain, the examination can be completed after a topical anesthetic has been administered. Occasionally, soft

tissue radiographs of the neck are helpful in delineating the superior and inferior aspects of the tumor. This is especially true, if the bulk of the tumor prevents an adequate inspection of the nasopharynx or hypopharynx.

The impression of epithelial cancer of the tonsil is confirmed by biopsy of the lesion. An adequate amount of tissue should be removed from the primary lesion in order to allow the pathologist the opportunity of arriving at a specific histologic diagnosis. In general, it is felt that biopsy of the cervical lymph nodes is not absolutely necessary, provided there is a reasonable possibility that the histologic diagnosis can be made from a biopsy of the intraoral lesion. If a histologic diagnosis of the lymph nodes, as well as of the primary, is essential, a punch biopsy of the lymph node would seem to be preferable to excision of a discreet lymph node or group of lymph nodes in the neck.

The histologic appearance of the epithelial cancers of the tonsil does appear to be related to the response to radiation therapy. (Lymphosarcoma of the tonsil has been excluded from the scope of this discussion. It is generally recognized that lymphosarcomas of the tonsil are more radiosensitive than epithelial cancers of the tonsil.) There is a definite correlation between radiation response and the degree of differentiation of the cells in the epithelial cancers of the tonsil. The radiosensitivity is reflected in the clinical work of Ennuyer and Bataini. In their series which includes all of the cases treated at the Fondation Curie in Paris, cures were effected in 15 per cent of patients who had moderately well differentiated squamous tumors of the tonsil. The five year survival rate for patients having poorly differentiated or undifferentiated squamous tumors was 24 per cent.

Most Common Site—Lymph Node

The most common site of metastatic lymph node involvement is in the lymph nodes in the superior carotid chain immediately subjacent to the angle of the mandible. Only 23 per cent of all the patients presented themselves without clinically positive lymph nodes. On the other hand, 77 per cent of the patients had nodes which were considered clinically to be involved with metastatic cancer. Of the patients who had clinically positive nodes, 84 per cent had unilateral lymph nodes; 16 per cent had bilateral involvement. The lymph nodes are involved in the following frequency:

- (1) homolateral superior carotid lymph nodes
- (2) homolateral middle carotid lymph nodes
- (3) contralateral superior carotid lymph nodes
- (4) homolateral submaxillary lymph nodes

(5) homolateral inferior carotid lymph nodes

The supraclavicular and spinal accessory lymph nodes are involved only rarely.

This distribution of lymph nodes suggests the necessity of treating all of the homolateral carotid lymph node chain and the superior carotid region on the contralateral side. The submaxillary areas are usually irradiated but the lower spinal accessory nodes are not irradiated.

The treatment of choice for the lesions at this time is radiation therapy. There have, in the past, been numerous surgical procedures utilized in the treatment of these patients. For the most part, the complications and the poor cure rate have resulted in the termination of the surgical treatment for carcinoma of the tonsil. Very few surgeons advocate the treatment of these lesions of the tonsil by surgical means.

Radiation therapy is administered to the primary, to the involved lymph nodes, and to the potentially involved lymph nodes. In general, the primary and the node bearing area should be treated in continuity or contiguity. The node areas which are included in the irradiated zone are the submaxillary and the entire carotid chain on the homolateral side, as well as the superior carotid lymph node area on the contralateral side. If clinically positive contralateral nodes are present, the entire carotid lymph node chain on the contralateral side should be irradiated.

Treatment by Means of Conventional Apparatus

Most of the clinical experience which can be evaluated has been obtained through the use of conventional (180-250 KV) apparatus. A suggested mode of treatment by means of conventional apparatus is as follows:

For the Primary Lesion:

- (1) External radiation therapy is given to the primary lesion primarily by two parallel opposing lateral fields. A tumor dose of approximately 4500r in six weeks is given. An additional small single submaxillary field is occasionally employed on the homolateral side.
- (2) In addition to external radiation therapy, either
 - (a) radium or radon seed implantation or
 - (b) oral radiation therapy is employed.

For the Regional Nodes:

The involved or potentially involved lymph node area in the neck are treated with external radiation. Total skin doses of 4500r are delivered to the upper cervical areas at the rate of 125r skin per day. 4000r skin dose is delivered to the lower cervical areas at the rate of 100r per day. If residual palpable lymph

nodes are present following this treatment to the neck, an additional 1000 to 1500r may be given to very small fields encompassing the residual palpable disease.

Intraoral Therapy

If it is elected to administer intraoral therapy as a part of the treatment, it is essential that adequate exposure and adequate equipment is available, in order to utilize this modality. If interstitial radium or radon is used, one must take care in the planning and execution of the implant. Radium needle implantation of the soft palate and tonsillar fossa is somewhat difficult, due to the resiliency of the tissues. Radon seed implant in these areas can be performed with only moderate difficulty. The patient tolerates radon seed implantation in this area better than radium needle implantation. However, there is great difficulty in performing a radon seed implantation in such a way as to obtain "uniformity" of dose. In those tumors of the palatine tonsil, which invade the tongue, radium needle implantation may be done with moderate ease and accuracy. If interstitial radiation therapy is deemed necessary, I prefer to perform radium needle implants.

Supervoltage Therapy

If supervoltage radiation therapy is available, the overwhelming majority of patients with epithelial cancer of the tonsil can be treated by means of external radiation therapy only. Intraoral therapy or interstitial radium or radon therapy is seldom necessary. With this supervoltage radiation therapy, an adequate tumor dose can be delivered, employing external radiation only. A suggested mode of treatment, applying supervoltage therapy in the range of 1-4 MEV, is as follows:

For the primary lesion:

External radiation therapy employing two parallel opposing lateral fields—a tumor dose of 6000r in five weeks. An additional 1000r tumor dose in five days may be delivered to residual palpable disease.

Neck:

A given dose of 5000r in six weeks plus an additional 2000r in five days through very small fields to residual palpable nodes.

Some early investigators feel that the survival rates for patients having epithelial cancers of the tonsil will be improved through the use of supervoltage apparatus.

Prognosis following radiation therapy for epithelial cancers of the tonsil may be correlated with the sex of the patient, with extent of the lesion when the patient is first seen and the presence and character of the lymph nodes.

In patients having epithelial cancers of the tonsil,

wherever there is inflammation, swelling, pain

VARIDASE[®]

Streptokinase-Streptodornase Lederle

BUCCAL Tablets

conditions
for a fast
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comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. VARIDASE speeds up this normal process of recovery.

By activating fibrinolytic factors VARIDASE shortens the *undesirable phase*, limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells.

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*for routine use in injury and infection
...new simple buccal route*

VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption, patient should delay swallowing saliva.

Dosage: One tablet four times daily usually for five days.

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Each VARIDASE Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase.

Supplied: boxes of 24 and 100 tablets.

1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission



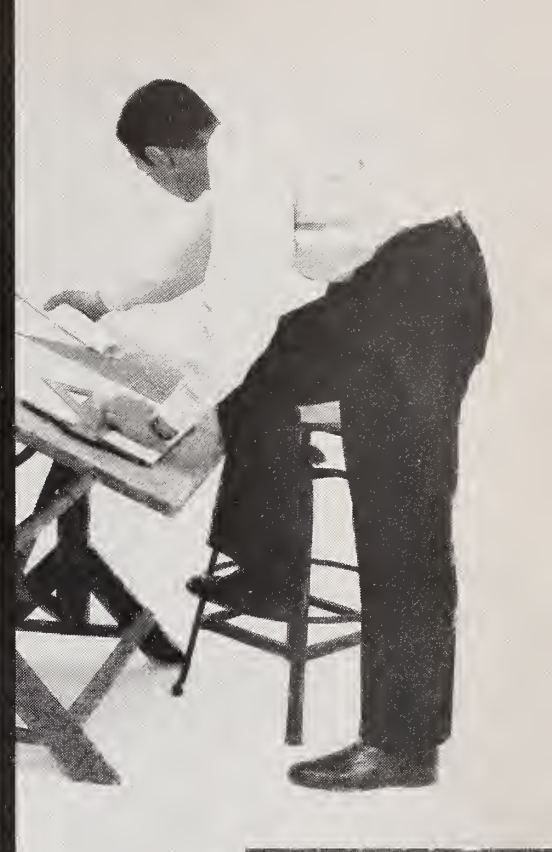
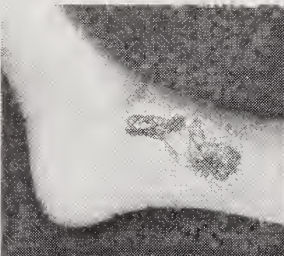
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FORCE INJURY
severe bruises
... swelling
... cleared
by fifth day²



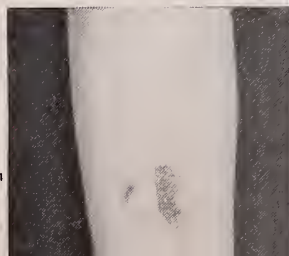
**VARICOSE
ULCER**
15 years duration
... resolved with
VARIDASE¹



**INFLAMMATORY
DERMATOSIS**
rapidly spreading
rhus dermatitis
healed within
a week¹



**INFECTED
LACERATION**
marked reversal
in 3 days...
returned
to school...
closure advanced¹



THROMBOPHLEBITIS
back on his feet
in a week after
recurrent episode¹



**REFRACTORY
CELLULITIS**
normal routine
resumed after 4 days
of VARIDASE¹



PALATINE TONSIL / Dillon

the five year survival after radiation therapy was (Ennuyer and Bataini) 35 per cent for females and 16.5 per cent for males. In their study of lympho-sarcomas of the tonsil, this variation in response in males and females was not noted. In their patients who had lymphosarcoma of the tonsil, the five year survival in females was 38 per cent; in males 35 per cent.

Ennuyer and Bataini also observed definite relationship between extension of the tumor and five year survival. Their findings are as follows:

<i>Prognosis Site</i>	<i>5 Year Survival</i>
(1) Localized to tonsil	35%
(2) Tonsil and anterior pillar	38%
(3) Tonsil and both pillars	20%
(4) Tonsil and soft palate	20%
(5) Tonsil and tongue	19%
(6) Tonsil—soft palate—tongue	17%
(7) Tonsil and buccal mucosa	15%
(8) Tonsil and lateral wall of oropharynx	5%
(9) Tonsil—posterior pillar—posterior wall of oropharynx	0%

These investigators at the Fondation Curie in Paris also demonstrated the relationship of adenopathy to the five year survival. Their findings are listed below:

<i>Prognosis in relation to adenopathy</i>	
Without nodes	21%
<i>With nodes:</i>	
(1) Single homolateral	22%
(2) Multiple homolateral	10%
(3) Bilateral nodes	
Single contralateral node	21%
(4) Bilateral multiple	8%

It is interesting to note that the five year survival rate for patients without nodes or with a single homolateral node or with a single node in each side of the neck are essentially the same, approximately 20 per cent. Also, if there are multiple nodes, either homolateral or bilateral, the five year survival rate is much less, approximately 10 per cent. It is apparent then that a multiplicity of nodes rather than the bilaterallity is the factor which affects the prognosis.

Mode of Failure with Radiation Therapy

If one seeks to improve a well established technique of therapy, he must first determine the nature and character of the failures of the technique. Ennuyer and Bataini, in their brilliant study, have determined the mode of failure in patients with epithelial cancers treated by radiation therapy. Their findings are listed:

Causes of Death After Radiation Therapy Within Five Years

(1) Recurrence in primary site	34%
(2) Recurrence in primary and regional nodes	33%
(3) Intercurrent disease	7%
(4) Distant Metastases	5%
(5) Second cancer of digestive tract	3%
(6) Recurrence in primary and distant metastasis	2%
(7) Other	12%
Death five to ten years	
All cases	4%

It is of great significance that the primary disease was not controlled in approximately two-thirds of the patients who were not cured by radiation therapy. This factor would seem to indicate that a more effective method or technique for controlling the primary disease must be sought, if substantial improvement in the prognosis of these epithelial tumors of the tonsil is to be obtained. It must be remembered that these statistics published by the workers at the Fondation Curie represented work performed before the advent of supervoltage therapy. It is felt by many radiation therapists that supervoltage therapy will allow for a more vigorous and effective attack on the primary disease. Already in the literature, there are indications in preliminary reports that the primary disease in these patients with epithelial cancers of the tonsil will be controlled more frequently with supervoltage radiation therapy than with conventional (180-250 KV) apparatus.

If, after a suitable trial, supervoltage therapy proves to be no more effective in controlling the primary than conventional radiation therapy, the possibility of a combination of radiation therapy followed by limited surgery, perhaps electrocautery, might be considered, on a trial basis.

Medical College of Georgia

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MAG ANNUAL SESSION

MAY 1-4, 1960

Columbus, Georgia



A Special Report
MENTAL ILLNESS
IN GEORGIA



THE PATIENT AND STATE GOVERNMENT

*A statement by the Honorable S. Ernest Vandiver,
Governor of the State of Georgia.*

A GEORGIA HISTORIAN may someday note that 1959 was the year of our awakening to the problems of the mentally ill in our State. The scales were dropped from our eyes following the report of the Schaefer Committee of conditions at Milledgeville State Hospital and we stood naked and ashamed in the revealing light of a situation that had been allowed to exist too long. It would have been even more shameful if we had closed our eyes again and allowed the situation to continue. But thank God we did not. And when I say "we" I mean every Georgia citizen for we were all equally responsible and we are all now ready to right these wrongs.

The transfer of the Hospital to the Department of Public Health was the initial step. Dr. Thomas F. Sellers, then director of that Department, and Dr. John H. Venable, then his assistant and now director, immediately began a comprehensive study of the conditions and took action or made recommendations for improvement as rapidly as money and personnel was available to them. In the nearly nine months since the transfer of the Hospital my confidence in them has increased and has constantly been reconfirmed. Securing an outstanding psychiatrist like Dr. Irville H. MacKinnon to be superintendent of the institution convinces me that we are on the right road, but let us not forget that the road to

what we ultimately hope to accomplish is a long and far reaching one.

There are few more than 50 psychiatrists in the State of Georgia. If we had every one of them working at Milledgeville among the 12,000 patients there still would not be enough to go around. Our only hope is to train our own and the beginning steps have been taken to bring this about. Emory University and the Medical College of Georgia are cooperating with Dr. MacKinnon and the Health Department to get this established. Let us remember, however, that even after it is started, it may take 10 years before we see concrete results. It's going to take long-range planning like this for the results we hope to accomplish.

Many changes need to be made in patient housing at the hospital. Some of the buildings are modern and well equipped. Others are shamefully old and dilapidated and need to be replaced at once. Patients have been moved around and reassigned to existing buildings and at least one century old dormitory has been closed and torn down. Studies are being made to determine what new types of buildings need to be constructed since the place where a patient lives is as much a part of his therapy as anything that is done for him. We want to provide a place that will become a part of the "therapeutic community" in which a patient is restored to his health, not just a roof and four walls, no matter how modern.

The importance of good, tasty, well-prepared food served hot and in an appetizing manner cannot be denied in the care and treatment of any sick person. A study of the food service at the Hospital revealed that food is being prepared and served in 29 different ways in 29 different kitchens. The Health Department has plans for one central kitchen to serve all patients and staff with the food dispensed by truck to the various buildings. This will not only insure all patients getting wholesome meals, but also will cut costs, in buying, preparing, and serving.

Sanitation in a large community like Milledgeville State Hospital is just as essential as in any city of comparable size. Food, housing, garbage, sewage, and all elements of the environment need sanitary han-



Governor Vandiver meets individual patients during his personal tour of the hospital. Following his visit, the hospital was inspected by all members of the Georgia General Assembly and state newspaper editors.

ding for the health of all concerned. A full time sanitarian is now employed at the hospital to work with the staff. Garbage disposal in a sanitary landfill, a method of burying garbage with a bulldozer is now in operation at the hospital and soon many low areas can be filled in, providing level ground for additional buildings and parking spaces. Plans for a sewage disposal plant to be operated jointly by the hospital and the City of Milledgeville are now being explored.

But regardless of how well we improve the physical and environmental conditions at Milledgeville, our primary concern is how well we can improve the mental condition of the patients committed to the institution. The patients—all sons, daughters, mothers, fathers, and children of Georgia citizens—must always be our first consideration. As each new patient is admitted to the hospital he needs to be carefully screened and tested so that the best therapy for his

speediest recovery can be determined. Our goal is not to *retain* him but to *return* him to his family, his friends, his community, and his work as rapidly as possible. How well we are going to be able to do this depends on many things. We need more buildings, doctors, nurses, attendants, psychiatrists, social workers, occupational therapists, recreation directors, in fact more of every service we are now offering at the hospital and then some. Mrs. Vandiver and I are both vitally concerned about the care and treatment of the mentally ill in our state. We are ready to work with every interested group and individual to achieve success in this program. But it cannot be accomplished by one governor, one association or one individual no matter how deep the concern. It is going to take *all* of us pulling together toward our goal to bring to a reality our dream for a sound mental health program in Georgia.

THE PATIENT AND A STATEWIDE PROGRAM

*A Report to the Medical Association of Georgia by its Representatives
on the Advisory Committee on Mental Institutions*

THE UNDERSIGNED ARE TWO members of the Advisory Committee on Mental Institutions appointed by Governor Vandiver by Executive Order on May 26, 1959, to represent the Medical Association of Georgia. The Advisory Committee on Mental Institutions organized at its first meeting in Atlanta on June 5, 1959. Since that time the Committee has met each month, one meeting having been for two days in July at Milledgeville State Hospital at the time the Governor and Mrs. Vandiver as well as Legislators and their wives inspected the Institution.

The Advisory Committee on Mental Institutions is composed of persons appointed by Governor Vandiver from nominations of the Medical Association of Georgia, the Georgia Psychiatric Association, the Georgia Association for Mental Health, the Georgia Bar Association, the Georgia Academy of General Practice, and the Georgia State Chamber of Commerce.

The Advisory Committee has considered all aspects of the program for mental health and given advice to the State Department of Public Health, the Governor, the Governor's Commission on Economy and Reorganization, the Joint Legislative Committee on Mental Health and, through the newspapers, has kept the public aware of the problem to some considerable degree.

The substantive work of the Advisory Committee can best be summarized by quoting here, "Some Recommendations in A Program for Mental Health," adopted at the December 9 meeting of the Advisory Committee.

Respectfully submitted,
Luther H. Wolff, M.D.
R. Hugh Wood, M.D.

Recommendations in a Program for Mental Health

After half a year of extensive study and thought, the Advisory Committee on Mental Institutions submits this statement summarizing its work and proposing some steps and direction for the Georgia Program for Mental Health in the coming months. These recommendations are made to the Department of Public Health for the Department's use and for transmitting to the Governor, the State Board of Health, and the various groups of the Legislature and the public.

General Objective of the Program

The general objective of the program for mental health is to provide the facilities and climate by which the mentally ill citizens of Georgia, including those presently ill and those who will become ill, may receive proper psychiatric care and treatment

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with a reasonable expectation of recovery and return to healthy life in the community.

Three conditions must exist to make such a program possible:

(1) There must be an interested and informed citizenry willing to give time and money to the program and believing in the desirability of providing optimum State facilities for the care and treatment of the mentally ill. Georgia has responded with the necessary interest to the information widely and thoroughly disseminated by an enlightened press. The Advisory Committee believes that this first condition now exists.

(2) The Program should be led by the Governor of Georgia who considers it among the most important of his responsibilities. By his courageous action in transferring responsibility to the Health Department pursuant to the recommendations of the Schaefer Committee, Governor Vandiver has demonstrated his statesmanly intent to lead a program which is "second to none." The Advisory Committee believes that he will continue to do so.

(3) The Program must be sound and based on present-day psychiatric knowledge of the organization and administration of a mental health program. The Program must be based on long-range goals proceeding in orderly fashion. Dr. Irville MacKinnon contributes this knowledge as Superintendent of Milledgeville State Hospital but the Advisory Committee emphatically states that Dr. MacKinnon is faced with herculean tasks at the Hospital and cannot even meet those tasks without vigorous and sound leadership of the State Program.

The Advisory Committee believes that a beginning has been made in all of these important areas. However, this beginning is only a ray of light for the patients whose lot thus far is not tangibly better than it was a year ago except for the element of hope.

The specific recommendations made hereafter have been carefully ranked according to importance by the Advisory Committee, the members of which unanimously feel that it is essential to sensible planning to secure first "brains," that is, trained, efficient personnel for the Program, and only secondarily to concern ourselves with bricks and mortar.

For action in the next few months, the Advisory Committee recommends as follows:

Division of Mental Health

The Advisory Committee supports the action taken on October 14, 1959, to create a Division of Mental Health within the Department of Public Health, effective January 1, 1960. The Committee

recommends that the Division of Mental Health be headed by a Director who is invested with full responsibility and the authority to direct the Division. The Director of the Division should be a psychiatrist certified or eligible to be certified by the American Board of Psychiatry and Neurology. He should have had at least three years experience in a mental institution at the rank of Clinical Director or higher or in a State Mental Health Program as a responsible official. The Committee advises that, in its opinion, such a psychiatrist should be offered an attractive salary commensurate with his ability, responsibility, and experience. Responsibility should be given the Director of the Division of Mental Health for the statewide program for mental health including responsibility for Milledgeville State Hospital and Gracewood Training School for Mental Defectives, the intensive treatment program, community clinics, training and research, and coordination of training in State institutions with the medical schools. The Director should be responsible to the Director of the Department of Public Health and the State Board of Health.

State Board of Health

The Advisory Committee recommends that the State Board of Health be so constituted that adequate representation is there given to the specialty of psychiatry, including a member appointed by the Governor from two nominations by the Georgia Psychiatric Association.

Financial Support

The Advisory Committee believes that the people of Georgia will support to the fullest extent the designation of sufficient funds to make possible a long-term program for mental health leading to the maximum improvement for the care and treatment of our mentally ill. The Committee emphasizes the importance of concentrating on the improvement of professional and other staffing at Milledgeville State Hospital and, in the State at large, on adequate funds for intensive treatment programs with emphasis on developing the psychiatric units of general hospitals and the establishment of small psychiatric hospitals near major centers of population and for training and research in centers of medical education.

One suggestion, for example, has been that the designation of budget for Milledgeville State Hospital be increased one million dollars in the first year, two million in the second, three million in the third, four million in the fourth, and five million dollars in the fifth year of our new program. The Advisory Committee points out that, under such a budget, should the population at Milledgeville State Hospital stay level, and not increase, in the fifth year, it should be

noted that our expenditure of five million dollars a year above the current budget will permit an increase at only one dollar a day per patient to a total of approximately \$3.50. This figure will not even then equal the national average.

The Advisory Committee further emphasizes the tremendous importance of a well-planned and sufficiently budgeted statewide program. Intensive treatment programs are expensive but money on them is well-spent. Of the first 578 patients treated in the intensive treatment program of the Georgia Department of Public Health, reliable psychiatric opinion demonstrated that of those treated 70 per cent would, except for the intensive treatment averaging between three and four weeks have had to be committed to Milledgeville State Hospital. Only nine per cent were still recommended for long-term hospitalization. We know from past history that, of those committed to Milledgeville State Hospital, a large percentage stay for the balance of their lives at the cost of the State. Intensive treatment is demonstrably a sound investment.

Similarly, attention should be directed to the fact that the more adequate staffing of all psychiatric programs in Georgia is a bootstrap operation. Professional personnel (physicians, social workers, psychologists, occupational therapists, rehabilitation specialists, and nurses) are not available in sufficient numbers. Financial support of the programs at our medical schools and coordination of the facilities at Milledgeville State Hospital with them are essential and any money devoted to these purposes will be well-spent.

As the points already made will show, the Advisory Committee believes that new construction and major improvements should be considered matters for capital outlay and funds separate from the general budget should be made available for them.

The Advisory Committee points with pride to the public support already shown for the voluntary gift of a Chapel of All Faiths to the patients at Milledgeville State Hospital by the people of Georgia. The Committee believes this adequately demonstrates the concern of Georgia for the mentally ill. From this attitude adequate support for any sound program will be sure to come.

Grants-In-Aid

As part of the financial support needed for our Operation Bootstrap in providing personnel for the care and treatment of the mentally ill, the Advisory Committee supports and strongly recommends to the people of Georgia the adoption of the Constitutional Amendments in the next General Election to afford grants-in-aid to help train staff for mental health programs.

Commitment Laws

In 1958 the General Assembly enacted a humane and practical commitment law. Dr. Irville MacKinnon, Superintendent of Milledgeville State Hospital, has advised with the Joint Legislative Committee on Mental Health and this Advisory Committee on the slight changes in the 1958 law necessary to make it more workable and humane. The Advisory Committee strongly recommends the enactment of this legislation and repeal of inconsistent laws. At the same time the Advisory Committee points out to the citizens of Georgia that the most humane law for commitment of the mentally ill will fail in its high purpose if patients must, for want of proper hospital space, be committed to the common jail pending legal proceedings. In many counties in Georgia, mental patients are placed in jail to await commitment or hospitalization. All Georgians should find out what is happening in their own counties. If patients are being left in the jails, everyone should let his interest be known.

Family Responsibility

The Advisory Committee believes that one of the saddest aspects of Milledgeville State Hospital is that, in the past, patients have been abandoned to the care of the State with families frequently treating the committed patient as dead. This uninformed attitude actively militates against improvement of the patient's condition dependent, as it is, on love and a sense of belonging to the community outside the Hospital. Recognizing this point, the Advisory Committee recommends that the family or estate of the committed patient share the cost of hospitalization with the State, commensurate with ability to pay. The Advisory Committee also recommends that the funds so collected be accrued in a special fund to be devoted entirely to training and research in the field of mental health. Thus, families of patients committed to the care of Milledgeville State Hospital can feel that the funds they pay are being used in a way calculated to help their loved ones most directly.

Gracewood Training School

The Advisory Committee recommends that administrative responsibility for Gracewood Training School for Mental Defectives be transferred to the Division of Mental Health of the Department of Public Health.

Role of Advisory Committee

The Advisory Committee believes that its role has been, and will be, important in helping to recommend over-all planning. In order better to serve, the Advisory Committee has appointed stand-

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ing subcommittees, the members of which will be fully authorized and ready to work and advise between the monthly meetings of the full Committee. The best efforts of everyone interested in the Program are needed in carrying forward from the beginnings made this year. Therefore, the Advisory

Committee, serving at the pleasure of the Governor, resolves to continue its work with utmost vigor.

Respectfully submitted,
The Advisory Committee on
Mental Institutions
By William Rottersman, M.D.,
Chairman

THE PATIENT AND RELIGION

Louie D. Newton, *Chairman*

Committee on the Chapel of All Faiths
Milledgeville State Hospital

PLATO SAID: "If the head and the body are to be well, you must begin by curing the soul." That sounds like good reasoning, and it is affirmed by the top men in psychiatry and other fields of medicine.

Dr. T. F. Sellers, Sr., retiring Director of the Georgia Department of Public Health, his successor, Dr. John H. Venable, and the new Superintendent of Milledgeville State Hospital, Dr. I. H. MacKinnon, declare that one of the essential needs at our State Hospital is an adequate and attractive center of worship.

It was this conviction that prompted Governor Ernest Vandiver to create the special committee to provide the Chapel of All Faiths for the 13,000 patients at Milledgeville State Hospital, and the prompt response of every person invited to membership on the committee is indicative of the readiness

of every person invited to membership on the committee is indicative of the readiness of our people to build this center of worship.

The plans have been approved, providing a central Chapel of Georgian-Colonial design, seating 1,000 persons, with adequate provision for a spacious fellowship lounge and conference rooms for the Chaplains on the ground floor, and separate Chapels for Catholics and Jews, all tied in through a pattern of architecture which will please everyone.

We believe that this center of worship will be of inestimable blessing to the patients, through the ministry of well trained Chaplains and the cooperation of the entire Hospital Staff. If Plato was correct, and if the experienced and trusted leaders in medicine today are correct, supported, as they are, by all of us who have sought to render spiritual help for these mentally ill neighbors, then we are on the right track in asking Georgians to give the money to build the Chapel of All Faiths.

Many patients have already expressed great satisfaction in the promise of the Chapel. This is an appeal to every Georgian to share in this united effort to do something worthwhile today and for generations to come for the friends who need the best possible atmosphere in which to get well. Thanks for your interest. Please mail your check to Mr. Mills B. Lane, Treasurer, Chapel of All Faiths Fund, Citizens and Southern National Bank, Atlanta. The architects estimate that the Chapel, furnished, will cost \$750,000. We hope to raise \$1,000,000, and thus insure a modest endowment for the Chapel.



Architect's rendering of proposed Chapel of All Faiths at Milledgeville State Hospital. Present religious facilities at the hospital are inadequate.

THE PATIENT AND THE HOSPITAL

Irville H. MacKinnon, M.D., *Milledgeville*

NEVER IN ALL MY experience have I seen such public interest and enthusiasm for mental health. I have been moved deeply by this enthusiasm for projects so important to the State. Along with this tremendous enthusiasm, I never realized there were so many people and organizations interested in a mental hygiene movement. Somebody has done a lot of road work. Mental health has been sold, and sold very well.

There are some dangers, however, in the stimulation of such great enthusiasm. We have to be very careful that the public will not be let down. This is the time when we must take advantage of this situation and carry it on to further heights. I would also say that among this large number of organizations there may be some overlapping. The question is how to bring these together, to coordinate them. There are plenty of guns and plenty of ammunition, but I am quite hesitant as to whether we are hitting at the target. Everyone is asking me what they can do and how they can do it. I would like to work together with these groups in furnishing a target.

If the patient feels that the public is interested in his problems, that it understands and sympathizes with his interests, this in itself has a great therapeutic value.

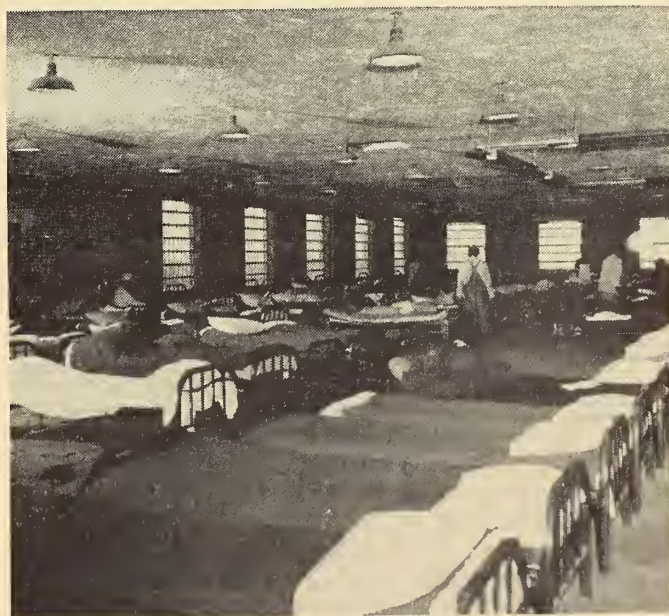
It is difficult to change the centuries-old stigma that has been placed upon mental illness. We all know that the mentally ill person was once thought to be infested with the devil—that little gremlins related to the devil crawled through the pores of the skin of the psychiatric patient and got hold of him, distorted his mind and produced this so-called mystical type of disease. Even today the person with mental illness wants to hide it. But he would like to have the attitude that this is an illness the same as any other organic illness—that the mind is an organ like the lungs, the heart, and the liver, which can become affected. The new attitude of the people in Georgia that something is going to be done will relieve some of the stigma. The press, radio, and television will do a great deal to popularize the facts and information for the public. They are welcome at any time at the Milledgeville State Hospital. The doors are open, we have no secrets, and I will be

only too happy to furnish the information and facts that might be of interest to the people of Georgia.

The people in the neighborhood of Milledgeville have cooperated in every way. The legislators who have visited the hospital in recent weeks and have seen first hand the conditions that exist and need correcting have assured me of their support. The Georgia Department of Public Health, of which I am a member, has gone all out to make me feel comfortable and assure me of support. The personal interest taken by the Governor of Georgia is one of the chief sources of the ray of hope that now has begun to shine on Milledgeville State Hospital.

Now what about other things that are good for the psychiatric patient? If there is any way possible for human individuals to be admitted to the mental hospital on a voluntary basis without having to be legally committed, this in itself will be a tremendous benefit. I believe that the commitments should be simple and understood by everyone, and provisions should be made that patients be admitted immediately the same as they would be to any surgical or medical hospital. The psychiatric patients should not be made to wait a week or 10 days in local jails or other institutions not prepared to care for them adequately.

Also, I believe that the development of centers for the treatment of psychiatric patients will go a



On some wards, as above, space shortages require row upon row of beds to be jammed together with practically no space between them.

Dr. MacKinnon, former professor of psychiatry at Columbia University, recently took over as Superintendent of Milledgeville State Hospital.

PATIENT AND HOSPITAL / Mental Health Section

long way toward helping to eliminate the stigma. I believe that patients will go willingly to treatment centers connected with our modern hospitals where there are teaching facilities, where there are medical students, where there are residents in training and where there are associations and affiliations with other medical facilities of the hospital. I am quite sure that the general practitioners, the families of the sick patients, will encourage patients to go there agreeably, because they are part of a general medical treatment. It is a total situation which will bring psychiatry closer to an acceptance in the medical circles and fields. It will also introduce psychiatry to the other specialties where the practitioners can hobnob and work together daily, where in their consultations they can meet and talk over the problems and approach all of our medical situations in a total manner.

Early Treatment—Early Results

If the patient goes to his physician willingly, is detected as a psychiatric case, is referred to the hospital, and is treated early, he gets well quickly, and he avoids going to a state institution. I believe this is a major advance, and centers for this service should be developed in all of the large cities. It is going to be difficult of course to provide psychiatric services in a large state like Georgia where there are not as many large cities as in some other states. Here we have to provide some other method, some other measure of providing the many counties with facilities for examination and detection of mental illness.

There is a possibility of developing traveling teams of small groups of psychiatrists, social workers, and psychologists to go out into communities a half a day a week or twice a month and work with the children in the schools, with the adolescents, and with adults and try to furnish them some sort of

service. The Health Department is already working in this area, has very fine plans, and will cooperate with me in pilot studies of this nature which I intend to carry out.

I feel that some of the things I am beginning to institute at the hospital are making progress. I talked with the staff frankly and openly, and told them what my plans were. I agreed that it was possible that some of these ideas may not work, but if there were a mistake I would be the first one to correct it. I informed them I could not do the job alone, but required their help and cooperation. I have been assured of this, and they have all pitched in to help.

Progress That Has Already Been Made

Here are a few of the things that will work for the psychiatric patients that have already been organized and put into effect:

1. The morale has been straightened out greatly.
2. An intensive treatment program has been started in the male and female admission services. Every patient is interviewed within 24 hours after admission. The first week I was there I saw each new patient myself, introduced myself, and told them what we want to do for them to help them get well. I have turned this over now to a treatment committee, a group who interviews and screens out the patients each morning and transfers them to our intensive therapy team. This team includes the nurse, attendants, social worker, psychologist, and occupational therapist.
3. The third thing that has been started has been weeding out patients throughout the hospital and putting the various categories together. These in-

Dr. Irville Herbert MacKinnon, former professor of psychiatry at Columbia University, was recently selected as superintendent of Milledgeville State Hospital and assumed his duties in mid-September.

Dr. MacKinnon had been associated with Columbia University continuously since 1949 and had been professor of psychiatry since 1954. He was also attending psychiatrist at New York Presbyterian Hospital. He was administrator of the New York Psychiatric Institute and headed the training program of Columbia University, College of Physicians and Surgeons and the New York Psychiatric

Institute which is associated with the new York State Training Program for psychiatrists. Dr. MacKinnon also served as a member of the Lunacy Commission of the Governor of New York.

Born in Boston, Massachusetts in 1898, Dr. MacKinnon received his M.D. degree from Tufts Medical School in that city. He had further training at hospitals in South Dakota and Maine. He is a diplomate of the American Board of Psychiatry and Neurology and member of the American Medical Association and the American Psychiatric Association.

clude 2,000 seniles and arteriosclerotics. We have 700-800 epileptics, whom we are grouping into one building, and assigning one man as specialist in this particular field. He can do the electroencephalographic work, the neurological work, the pneumoencephalograms, and various other neurological studies to see what we can find in the brains of these particular patients. The diabetics have been segregated and moved into a treatment service and a medical man will be assigned to handle the diabetic problems. There are 250 children at the hospital. Some are quite ill and are in bed, on a vegetative level. All children will be placed together, and we are seeking a child specialist with organic as well as psychological training to assume the supervision of the children's building.

This is the start, and as time goes on we will go further into the program. We had to make a dent in the periphery, at some particular point, and it seemed logical to me to start at the entrance of the hospital.

I have a feeling that a large percentage of the cases I have interviewed and seen already are of short duration. They are cases that might be sick for a few weeks or months, and if we get them diagnosed and treated at once I am sure we can get them out of the hospital much quicker.

Good Psychiatrist Like Good Physician

A good psychiatrist like a good physician is the one who supports the self-restorative functions of the human body. He steps in where the individual is fatigued, tired, and exhausted, gives him rest, gives him a tranquilizer to lessen the tensions, fears, and the anxieties, so he can eat, sleep, feel better. The self-restorative functions can come in and work. If this doesn't work we have shock therapies. What do shock therapies do? I do not know what they do, but I look on them more or less as "atom smashers" or "dynamite" that breaks up abnormal patterns, disintegrates them, and separates them. The individual cannot have any fear, he cannot think, he cannot be unhappy, he cannot be depressed. His mind is put in a splint, at complete rest, so that the natural forces of human nature can come in and start working and help the person to get better. The self-restorative functions then restore the person, and with the guidance of the healthy atmosphere, the kind nurses, the understanding occupational therapists, the physicians who work with them and talk over their problems, all combine to bring the patient out of these profound disturbances.

At times these patterns get organized and formulated like ingots of iron. The normal part of the



These ancient fixtures are used daily by more than one hundred patients in the Dupree Building.

personality becomes more or less inactive and atrophy of disuse sets in. As the condition spreads and overwhelms the individual, he no longer has any normal processes. They are shrunk, they are inactive, they cannot help the person. The abnormal patterns have taken over completely.

Patients in this condition are the ones that we see in the back wards of our state hospitals. These are the ones that we do not know what to do with; they do not respond to our modern methods of therapy. These are the cases among which we have to do much research.

At the State Hospital, I am planning to put in a complete research division. No program—whether in business or in medicine—can be successful unless funds are devoted towards the development of research programs. We are recruiting for a person to take over the research program. If one cannot be found immediately, I will call upon Emory University and the Medical College at Augusta to allow me to utilize their staff, such as chemists and pharmacologists. If these staff members have assistants, or if they have funds and public health grants and would like to work at the State Hospital, they would be welcome. We are beginning to use the medical students also.

Recruiting Doctors Is Difficult

The problem of recruiting doctors is difficult, for the simple reason that it is a competitive field. Everyone in the country is looking for psychiatrists. There are about 10,000 psychiatrists in the United States; 15 years ago there were only 5,000. Georgia has about 50; there has been no residency training program here. Dr. Bernard Holland has instituted such a program at Emory, but naturally has had to start on a small scale. It takes 10 years to develop a teacher. We can have the facilities and we can have the money, but we must have the trained personnel,

PATIENT AND HOSPITAL / Mental Health Section

so temporarily we must import our teachers from the outside. We must pay the price and plug up the holes, and maybe later we can take care of the situation with our own program. We will be very shortsighted if we try to be too economical.

Both medical schools have been sending students to the State Hospital. This in itself gives our Hospital prestige. It is helpful to the patients, and it gives the nurses and the staff more spirited feelings.

With this type of combination approach I have high hopes for the future. People are welcome to come to the hospital. I am anxious to have volunteer and auxiliary groups, of which there are many.

The United Church Women have been very helpful in supplying the patients with recreation, with TV sets, and in furnishing some of the day rooms. I am very pleased to see that everyone wants to do something for our patients and I want to thank all who have helped.

Hospital Beds Urgently Needed

We have found that the hospital needs 1,000-1,500 beds of new construction to relieve the 35 per cent overcrowding that prevails in all buildings except the Powell Building (reception). In some cases where it is economical and speedy, there will be remodeling and additions to existing housing. On the other hand, certain buildings have been found to be fire hazards and unsuitable for proper patient care and these buildings must be evacuated as soon as possible.

Certain buildings are inadequate in facilities such as bathing, toilet, and recreation, and this must be



Another example of space shortage. Crowding such as this deprives patients of human dignity.

remedied as soon as possible. Day rooms need to be enlarged or added to especially in winter when the outside porches are not available for patients to spend their day time hours. We would like to have occupational therapy shops closer to the buildings where patients reside.

Improved Sanitation and Food Service

For improvement of sanitation and food service, we have secured the services of a full time sanitarian who has inspected all of the 29 kitchens, 86 dining rooms, dairies, and food processing units. He has made detailed recommendations concerning all of these. These recommendations include construction of one central kitchen. For this reason no major repairs will be made in kitchens if they can be postponed until the central kitchen is completed. Painting and repairing of floors, walls and tables is underway, and formica tops are being installed on all dining room tables.

All three dairies are being inspected monthly. We have ordered equipment which will enable the milk laboratory to also inspect food samples. New modern pasteurization equipment has been ordered. New milk dispensers and containers for each dining room will enable us to serve milk in a more sanitary manner. As soon as possible we will relocate the meat cutting room in the rear of the cold storage plant.

The hospital no longer has incinerators in back of the buildings. These have been replaced by a sanitary landfill in the rear of the Lawrence Building. The trash dump behind the poultry farm has been abandoned and this area is presently in good shape. The landfill enables us to keep all of our trash and rubbish buried and reduces the breeding places for flies, rats, and mosquitoes.

Routine inspections are being made of all sanitary facilities in the buildings, and reports are being made to the staff of the hospital.

A new security division has been established, which includes a police department, fire department, and a prison section. We have added three patrolmen and transferred two others from the farm and dairy division. Three patrol cars are being purchased.

More and Improved Fire Protection

Four firemen have been employed which gives us enough personnel on hand at all times to maintain and operate the equipment. Some new equipment has been purchased, and schools are being held weekly for the full time fire fighting personnel and volunteers.

A new prison building has been completed which we feel is modern and up to date, and we are utiliz-

ing the prisoners for the benefit of the institution and for the rehabilitation of the prisoners. We are using prisoners in the kitchens and various other units of the hospital operation, and have used prison labor for completion of four dwellings with plans for about eight more as soon as sufficient prisoners are made available to us from Reidsville Prison. We will staff practically all of the kitchens with prisoners, and will use them in the laundry and in the sewing rooms.

Each new thing done at the hospital and in the state mental health program only reminds us of the tremendous work that is yet to be done—and that will always have to be done. In addition to the won-

derful enthusiasm which helps make the task easier at the present, there must be found a way to continue that enthusiasm by producing results that can be seen and felt by the patients, their families, and their communities. There must be money spent for improvements, and a large amount of money. We have no choice, if we are to move forward and give our mentally ill citizens the care and treatment they deserve. We will have to think big, plan big, and spend big. And we will have to have the cooperation of every person, professional or non-professional, who can and will help.

PROGRESS OF INTENSIVE TREATMENT PROGRAM FOR BRIEF GENERAL HOSPITAL TREATMENT OF THE MENTALLY ILL

Trawick H. Stubbs, M.D., M.P.H., *Director,*

*Division of Mental Health,
Georgia Department of Public Health*

PHYSICIANS FROM 119 GEORGIA counties referred 670 voluntary patients to local health departments for approval for general hospital treatment for their mental illness during the first 21 months (through Sept. 30, 1959) of the operation of the Intensive Treatment Program of the Georgia Department of Public Health. The Health Department has purchased services from psychiatric departments in three general hospitals—Talmadge Memorial in Augusta, Macon Hospital, and Columbus Medical Center. Local health departments certify to the medical indigency of applicants and forward the application to the State Office. Hospitals admit patients from the group of approved applicants.

On March 1, 1960, when the fourth hospital, Grady Memorial in Atlanta, is added to this program it is anticipated that the state will be divided into districts so that patients from any one county will be expected to go to the nearest hospital. The placing of counties in districts will be determined by popu-

lation and available bed capacity in the hospitals.

Goals of Intensive Treatment Program

Of the first 538 patients discharged, professional opinion indicated that 70 per cent of these (375) would have needed to go at that time or later to the Milledgeville State Hospital if service such as the general hospital service had not been available. Following hospitalization nine per cent (49) of these patients were still recommended for hospitalization at Milledgeville State Hospital. These figures are of course very rough, but they indicate that this program is succeeding to a considerable degree in its goals of (1) providing earlier service for patients so that they will not require longer hospitalization, (2) providing services closer to home, and (3) offering service in a setting that encourages people to think of mental illnesses as they think of other illnesses.

INTENSIVE TREATMENT PROGRAM / Mental Health Section

Emphasis of Intensive Treatment Program

The emphasis of the Intensive Treatment Program is three-fold: (1) services are provided to individuals in need, (2) there is encouragement for the development of more adequate general hospital psychiatric service, and (3) facilities for training of psychiatrists and other mental health personnel are enlarged.

To be medically eligible for this program a person must have the referring physician certify that he (1) needs to be in the hospital and (2) will probably benefit by several weeks of treatment. A consultant psychiatrist must concur in this opinion. This program is, of course, a partial and limited service. We need to move ahead toward future development of programs for adequate psychiatric appraisal of every person before commitment is considered. In addition to general hospital services there need to be developed long-range plans for the other types of services and facilities that are needed to improve or fill gaps in existing programs. One advantage of the Intensive Treatment Program is that it will provide experience which will enable responsible agencies and persons to plan more effectively and more realistically.

Community Services Are Important

The Intensive Treatment Program involves more than hospital service and out-patient follow-up service. Community services are just as important, and paramount at the community level is the continuing service of the family physician, not only in providing overall medical supervision, but in providing follow-up services needed for the psychiatric illness. It is hoped that every patient will return to his family physician. Local health departments are the key agencies in helping the patients benefit from the total range of community resources, in addition to providing the service of their own public health nurses to the patient and his family.

The Southeast, with one-third of the U. S. population, has only one-tenth of the psychiatric beds in general hospitals. At a recent meeting of the A.M.A. Council on Mental Health in Chicago, one of the six sessions was on "Psychiatric Services in General Hospitals," the theme for the meeting being "Organized Medicine and its Relationship to the Hospitalized Psychiatric Patient." For some years the American Medical Association has officially supported the development of more adequate psychiatric services in general hospitals. In Georgia, the Inten-

sive Treatment Program helps move us in a desirable direction.

Several new developments in procedures for this program became effective the first of January. Physicians who want to refer patients to the program may obtain forms from local health departments, which they return to the local health department, certifying that the patient needs to be hospitalized and will profit from three to four weeks treatment. The corroborating opinion of a psychiatrist is required, and we are suggesting in the interest of efficiency that one of the psychiatrists at the hospital to which the patient will go might best be the consultant. The patient, or family will also submit an application to the local health department.

The local health department will apply directly to the hospital, with copies of all three forms being sent to the State Health Department. Emergency applications can be arranged by having the local health department telephone the hospital after the referring physician and a psychiatrist have certified to medical eligibility.

Supplemental Training

Stronger psychiatric departments in general hospitals will provide important supplemental training opportunities for psychiatrists and other personnel. This program should help both in residency level training and in continuing education for practicing physicians.

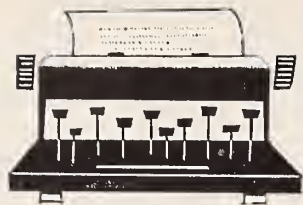
Encouragement is being given to a more effective line of communication between the psychiatrist responsible for treatment in the hospital, and the referring physician. During 1960 regular programs will be initiated in which the referring physicians will meet with psychiatrists in the hospital, sometimes in staff conferences at the hospital, and sometimes in special meetings at local medical societies or with local hospital staffs. Thus the service channel on this program can become an effective channel for continuing professional development and continuing education for physicians and psychiatrists.

Progress by Working Together

As this program grows, the Health Department enlists the help of all physicians in the state in making suggestions for guiding the future development of this program and other activities which should be developed to supplement existing programs. Thus working together, the many agencies and professions will insure adequate medical services to the mentally ill in Georgia.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Adams, Charles P.	478 Peachtree St., N. E. Atlanta	Active	Fulton
Aultman, Mims C.	E. Talmadge Memorial Hospital Augusta	DE 2	Richmond
Brown, Margaret L.	Student Infirmary, Emory Univ., Atlanta	DE 2	DeKalb
Dunn, Bryon H.	2910 North Druid Hills Rd., Decatur	Active	DeKalb
Foster, Harry R., Jr.	2556 Wiggins St., Lithonia	Active	DeKalb
Fregosi, Albert H.	2910 North Druid Hills Rd., Decatur	Active	DeKalb
Harden, Timothy, Jr.	603 Medical Arts Bldg., Decatur	Active	DeKalb
Johnson, Edward L.	2910 North Druid Hills Rd., Decatur	Active	DeKalb
Johnson, Henry C., Jr.	3130 Maple Drive, N.E., Atlanta	Active	Fulton
McDowell, Edwin H., Jr.	345 W. Ponce de Leon Ave., Decatur	Active	DeKalb
Morgan, David L.	2910 N. Druid Hills Rd., Decatur	Active	DeKalb
Middleton, Milton G.	Medical Building, Thomasville	Active	Thomas-Brooks
Olansky, Sidney	Emory Univ. Clinic, Atlanta	Active	Fulton
Oliver, Robert W., Jr.	North Washington Street, Lyons	Active	Southeast Ga.
Slade, Ira H., Jr.	124½ W. Poplar Street, Griffin	Active	Spalding
Smission, Hugh F., Jr.	University Hospital, Augusta	Assoc.	Richmond
Steinberg, Joel S.	Emory University Hospital, Atlanta 22	DE 2	DeKalb
Thompson, James R.	1406 Reynolds Street, Brunswick	Active	Glynn
Tillman, Ralph A.	Pearson	Active	Ware
Walz, Peter D.	2910 N. Druid Hills Rd., N.E., Atlanta	Active	DeKalb
Walters, Lamar H.	Emory University Hospital, Atlanta	DE 2	DeKalb
Whitman, Oscar F.	1109 N. Jackson Street, Albany	Active	Dougherty
Whittle, Michael H.	N. Washington Street, Lyons	Active	Southeast Ga.
Wills, Silas Angier	356 W. Ponce de Leon Ave. Decatur	Active	DeKalb



editorials

Mental Illness – Responsibility and Opportunity

FROM PRE-HISTORIC TIME TO THE end of the last century mental illness was not clearly divorced from theology, theosophy, and mysticism in the mind of the public or by the great men who represented medicine for many centuries. Witchcraft, possession, incubi, and werewolves are not the stuff from which can be fashioned a scientific medicine, and medical men gave these concepts of the causation of mental illness a wide berth. Further, the psychological theories which grew out of the romanticism of the early nineteenth century were abhorrent to a medicine trying to identify itself with the scientific work of men such as Auenbrugger, Morgagni, and Virchow. Then, to effectively repudiate its past replete with metaphysical theorizing, medicine proclaimed that mental diseases were somatic diseases—pathological reactions of the brain.

During the past half century there has developed an increasing understanding of the human personality as a functional whole, of the importance of the individual's experiences as he grows and develops and of the influences of a person's environment in determining whether the trend shall be toward illness or health. "It has been demonstrated that man may become sick because his social relations are defective, because his social environment is noxious, or because of innate, hereditary, or acquired

inability to deal adequately with his social relations—that is, with the reality he faces." *

Since World War II as a result of our increased knowledge of the "anatomy" and "physiology" of the personality, and advances in neuro-pharmacology, somatic-therapies, and psychotherapy, there has been a definite increase in the understanding and appreciation of psychiatric principles. This has helped dispel the prevailing attitude in many mental institutions that mental illness was not amenable to therapy. Many hospital staffs functioned primarily as custodians and many so called mental hospitals were merely "warehouses" for the mentally ill. Recent advances in the speciality of psychiatry have stimulated the development of vigorous programs erected toward aiding the mentally ill so as to restore them to mental health and return them to society. During the past two decades an increasing number of states have undertaken programs of great promise in the field of mental health. This has also been true of the Veteran's Administration and other branches of the Federal Government.

For over a century in Georgia, the state administration, the medical profession and the public have sorely neglected our mentally ill. The deplorable

*Gadston Iago: "A Progress in Medicine," New York, Alfred A. Knopf, 1940.

state of affairs at Milledgeville State Hospital has even recently led to such comments by high state officials as "food not fit for a dog," and "worse than the German prison camps." A little more than six months ago when an enlightened press called these miserable conditions to the attention of the public and state officials, Governor Ernest Vandiver in March of 1959 had the President of the Medical Association of Georgia appoint a committee* to study Milledgeville State Hospital. The report of the committee, popularly called the "Schaefer Report," was described by Governor Vandiver as "one of the finest, most authoritative, and all-inclusive public documents I have ever read."

Governor Ernest Vandiver one day after the receipt of the "Schaefer Report" and acting on its recommendations on April 24, 1959 transferred administrative control of Milledgeville State Hospital from the State Welfare Department to the State Health Department. By this prompt and wise act, Governor Vandiver has had the state, for the first time, clearly proclaim that mental illness is not to be differentiated from other illnesses—that the mentally ill are sick people entitled to the best of medical care, and that Milledgeville State Hospital shall be a hospital in the full sense of the term. A hospital where patients will receive good psychiatric (medical) care in a program that furnishes dignity and hope.

An Advisory Committee on Mental Institutions was appointed six months ago by Governor Vandiver. The appointment of the Advisory Committee was recommended by the Special MAG Committee to study Milledgeville State Hospital. The Advisory Committee* providing representation of diverse views; citizen as well as professional opinion can be extremely useful for consultation, discussion and advice, helping to stimulate and formulate plans for the care and treatment of the mentally ill of the State of Georgia.

The Advisory Committee recognizing that much of the effectiveness of State psychiatric services, institutional and non-institutional, depends on the kind

and quality of their administration, strongly supports the setting up of a Division of Mental Health within the Department of Public Health. This Division of Mental Health to be responsible for co-ordinating all state activities in the field of Mental Health. The Director of the Division of Mental Health to be a certified psychiatrist with adequate training and experience in the administration of a mental hospital. His qualifications should be equal to and preferably superior to any of the personnel he supervises. The Director of this Division should have definite responsibilities, and authority commensurate with his responsibility.

Concern for a long term, sound program is based on the history of mental health programs in a number of states which follows somewhat of a pattern. Often they start with an "expose" and considerable newspaper activity. State authorities take decisive measures demanded by an aroused citizenry. After a few years the mental health program begins to flounder, because it is not sound and based on present day psychiatric knowledge of treatment and administration. Usually failure to maintain adequate contact with the public and state government and thereby their support contribute to the ultimate demise of what was once a promising program.

Georgia's mental health program, though showing much promise, is young and fragile and to date has taken but a few faltering steps. Many years of devoted service and sound nourishment will be necessary before latent promises become fulfilled.

Public and state support are necessary for the program to grow and flourish. Continued support and understanding by the medical profession are equally essential for the ultimate success of the mental health program.

Physicians over the centuries have striven to aid those who are sick and in pain. Until today, most members of the medical profession have considered the millions of mentally ill as beyond the scope of their therapeutic resources. Today, accepting mental illness as being like any other illness—Milledgeville State Hospital as another medical hospital—the physicians of Georgia assumed a great responsibility. Accompanying this responsibility is a magnificent opportunity to, by treating the whole person, realize the greatest achievement in medicine.

Wm. Rottersman, M.D.

MEDICAL ASSOCIATION OF GEORGIA ANNUAL SESSION

May 1-4, 1960

Columbus, Georgia

*W. Bruce Schaefer, M.D.; John A. Bell, Jr., M.D.; Rives Chalmers, M.D.; Corbett H. Thigpen, M.D.; R. Hugh Wood, M.D.

*William Rottersman, M.D.; R. Hugh Wood, M.D.; J. L. Moore, Jr.; G. M. Bazemore; J. A. Bell, Jr.; M.D.; Rives Chalmers, M.D.; Peyton S. Hawes; Bernard Holland, M.D.; E. J. McCranie, M.D.; Louie D. Newton; R. A. Rainer, Jr., D.D.S.; Mrs. W. C. Tucker; L. H. Wolff, M.D.

Burns—Winter In Georgia

RECENT NEWSPAPER REPORTS are indicative of the impending catastrophes one may expect from burns in an heretofore predicted cold winter. Burn care is tedious, mortality severe, hospitalization prolonged and morbidity great. Early recognition during the "emergency period" of a specific problem requiring the most attention will frequently do a great deal toward overcoming the most pressing problem—morbidity and/or mortality. Particularly is this true in children who tolerate lengthy, intensive treatment poorly and in whom the death rate locally is appalling—60 each year for our state alone.

Children tolerate burn shock very poorly, and even in cases of major scalds (25 per cent body surface area or more), immediate intravenous fluid therapy will avoid major difficulties. The fluid of choice is Ringers-Lactate®, but saline and glucose will suffice. Needless to say that when the burn is the result of body clothing burning, the early treatment of shock is vastly more important.

Second-degree burns—reddening, blistering, and mild coagulation of the epidermis—will heal in 21 and not more than 30 days if the wounds are kept dry by the application of comfortable, bulky, dry

dressings which can be changed as needed. This type of dressing gives maximum comfort and avoids the impediment to healing and moisture that various emollients, antibiotic ointments, etc., produce. In essence, then, any wound remaining after this 21-30 day period of treatment and observation is a third-degree granulating wound and requires a skin graft providing the wound is greater in any measurement than 2 cm.

When a burn wound presents red granulation tissue slightly raised above normal skin level and is moist and glistening in appearance, repeated dressings will not improve the rate of healing and skin grafts are necessary. The sooner these grafts can be performed, the more quickly morbidity will be lessened, scarring reduced and the occurrence of septicemia avoided. Ideally, initial grafts should be applied as early as 21 days post-burn (or earlier if possible).

In the event of major burns about the head, face, and neck, tracheostomy is of inestimable value as both definitive and supportive therapy.

In addition, where local facilities are not available for burn care, transfer of patients to one of several burn-treatment centers in our state is most feasible.

PHYSICIAN OFFERS ADVICE ABOUT PATIENTS' FEARS

ATLANTA IS BLESSED with many good doctors.

Recently the city was favored with the presence of 6,000 in addition to the day-by-day coterie.

These were the members of the Southern Medical Assn. in convention.

They said many things encouraging to a public concerned about health.

One bit of advice helpful to all of us came from Dr. Francis X. LeTard of New Orleans.

This man of medicine was talking about the patient-doctor relationship when he said, "Get to know the patient . . . gain his confidence, anticipate his fears and problems and negate them with positive suggestions . . ."

We like that in a doctor.

We fear that which we do not understand.

The helpful, sympathetic practitioner fights fear in his patients by explaining that which we do not understand.

Dr. LeTard was talking specifically about allaying fears in regard to the anesthetic but his advice would be fine practice across the medical board.

Blessings on the doctor who has time to be human and helpful and sympathetic in his relationship with a fellow man in need of repair.

—The Atlanta Constitution



heart page

CARDIAC FLUOROSCOPY

MANY PHYSICIANS CONSIDER fluoroscopy of the chest a routine procedure in the clinical evaluation of their patients. It is well known that radiation exposure incident to fluoroscopy (roentgenoscopy) is about the highest encountered in the entire field of diagnostic roentgenology. On the other hand radiation levels incident to roentgenography (films) of the chest is comparatively small. For this reason we should now critically re-evaluate the relative merits of fluoroscopy and roentgenography in the study of heart disease.

Fluoroscopy must be performed with good equipment and with adequate safeguards to keep the radiation levels as low as possible. At least 2 mm. of aluminum filtration and at least 18 inches target to table top distance should be used. The roentgen output of the tube should be accurately known and for fluoroscopy of the chest at 65-85KV and 2-3 milliamperes, the roentgen output will usually be between 3 and 6 r per minute. The importance of dark adaption of the eyes for at least 15 to 20 minutes is well known. The smallest practical shutter opening should be used and fluoroscopy should be as short as possible to obtain the desired information. This time is usually three minutes or less and should deliver a maximum of about 18 r to the skin of the patient. This is to be compared with 1/10 r or less for an ordinary PA roentgenogram of the chest. In addition to the consideration of the marked difference in exposure both to the patient and to the examiner with fluoroscopy and radio-

James V. Rogers, Jr., M.D., *Atlanta*

graphy, one must consider the information that can be derived from the two types of examination. Let us consider for a moment the several features of cardiac anatomy or physiology about which information can be obtained by either of these methods.

Cardiac Rate—Cardiac Rhythm

It is not necessary to employ roentgenoscopy for evaluation of these features since they can be determined more accurately by other means.

Amplitude of Pulsations

Fluoroscopy is the best method for studying this feature. The amplitude of pulsation of the aorta, pulmonary artery and its hilar and intrapulmonary branches, and of the cardiac chambers might be very important in certain cases where increased or diminished amplitude of pulsations enters into the differential diagnosis.

Atrial Size

Right atrial enlargement is quite difficult to evaluate either at fluoroscopy or on film studies. Film studies are at least as accurate as fluoroscopy in this respect.

Left atrial enlargement can be detected by routine

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

films following a barium swallow with about the same degree of accuracy as on fluoroscopy.

Ventricular Size

The size of the ventricles can be evaluated as well if not better on routine film studies than at fluoroscopy. The contour of the heart in PA and lateral projection is the prime consideration in deciding which ventricle is enlarged.

Pulmonary Artery Including Its Hilar and Intrapulmonary Branches

The size of the pulmonary artery and its hilar and intrapulmonary branches can be evaluated as well if not better on routine chest films than on fluoroscopy. A distinction between pulmonary congestion, increased pulmonary blood flow, and pulmonary hypertension can frequently be made on routine chest films. Diminished pulmonary blood flow is readily apparent. In patients in which the pulmonary blood flow appears borderline on film studies, study of the pulsations is important. Fluoroscopy with the image intensifier makes evaluation of this feature much more accurate.

Aorta

The size and configuration of the aorta is readily determined on the routine films. The amplitude of

aortic pulsations can be studied only at fluoroscopy, and in selected cases it is important to study this feature.

Intracardiac Calcification

Frequently intracardiac calcification is readily visible on routine chest films of good penetration, however, valvular calcification is sometimes obscured on the roentgenograms due to slight motion, and it is more readily seen at fluoroscopy particularly with the image intensifier.

Summary

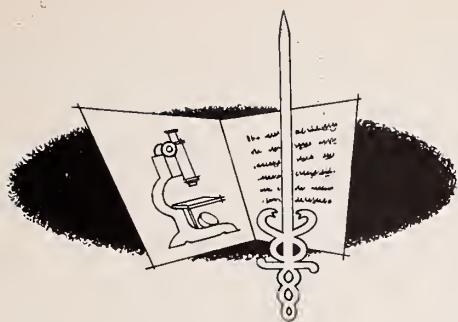
Routine chest films are probably superior to fluoroscopy in evaluating cardiac size and configuration, and probably nearly as good in evaluating pulmonary blood flow. In certain cases where intracardiac calcification is suspected or in which the amplitude of pulsations are important in establishing a diagnosis, fluoroscopy should also be employed. The proper way to roentgenologically investigate the heart is by routine films, and after a study of these, if fluoroscopy is indicated, then it should be performed. The major attention at fluoroscopy should be directed to the amplitude of pulsations of the pulmonary artery and its branches, pulsations over the ventricular contours, and pulsations of the aorta and of the left subclavian artery. Intracardiac calcification should also be searched for, and the size of the left atrium determined. Any abnormal compression or deviation of the esophagus should be evaluated.

CORRECTION

THIS IS A CORRECTION of the chart in the article "Multiple Malignancy" that appeared in the November 1959

issue of *The Journal of the Medical Association of Georgia* on the Cancer Page, page 572, by Thomas Harrold, M.D., Macon.

Case	Age	Year	First Malignancy	Case	Age	Year	Second Malignancy	Case	Age	Year	Third Malignancy
1	48	1932	Breast—Paget's disease	1	51	1935	Breast—Paget's disease				
2	75	1951	Breast—simple mastectomy	2	75	1951	Breast—simple mastectomy				
3	43	1947	Breast—radical mastectomy	3	45	1949	Breast—radical mastectomy				
4	64	1944	Breast—radical mastectomy	4	78	1958	Colon—resection				
5	65	1947	Cervix uteri—radiation	5	77	1958	Hard palate—radiation				
6	62	1953	Fundus uteri—hysterectomy	6	62	1953	Malignant carcinoid intestine				
7	60	1951	Larynx—laryngectomy	7	63	1954	Rectum—abdomino-perineal resection				
8	52	1945	Colon—resection	8	57	1950	Cervix—radiation	8	64	1957	Rectum—abdomino-perineal resection



cancer page

LARYNGECTOMY AND COLOSTOMY ORGANIZATIONS

A. H. Letton, M.D. and John P. Wilson, M.D., *Atlanta*

ONE OF THE PRICES that surgery for cancer frequently exacts as a payment for possible cure is the loss or partial loss of some body function. While some of the more extensive surgical procedures may result in considerable disability, often the degree of disability depends upon the patient's mental and emotional preparedness and the amount of practical instruction he may receive before and after his operation. Two of the more common procedures in cancer control which require substantial change in mode of living due to loss of normal function are laryngectomy and various procedures requiring the removal of the anus and rectum.

The patient who is to undergo an abdomino-perineal resection and one who is to have a laryngectomy have, primarily, two things in common: a tremendous apprehension of the loss of normal function and a need for rehabilitation to overcome this loss. It is to meet these needs that two most helpful auxiliary organizations, the Laryngectomee Association and the Georgia Ileostomy and Colostomy Association, have been formed. Their usefulness has been proven in the pre-operative and post-operative care of patients. The service that they render is incalculable and one which is unobtainable in any other manner or from any other source. There are times when even the most sympathetic and solicitous physician cannot reach and help the patient like "someone who has been through it." Not only

is the patient who has undergone a similar operation a source of personal encouragement, but frequently he is the source of better methods and devices. Indeed, many developments in the care of colostomies and ileostomies, for example, have been the product of patients' improvisations.

The Laryngectomee Association

The Laryngectomee Association was organized in 1951 by a group of patients who had undergone laryngectomy. The purpose of the association is "(1) To reach people facing the operation to remove the larynx and give them new hope for continued normal life and (2) to reach those who have had the operation and encourage and assist them to talk again." These purposes are accomplished by personally visiting patients both before and after surgery, to counsel and instruct as well as reassure. In addition, this group has been instrumental in the establishment of a course in pharyngeal speech at the Junior League Speech School in Atlanta, in which instruction by both speech therapists and laryngectomees is given.

This group has been active primarily in the Atlanta area. However, the association has a list of nearly 200 names of laryngectomees in all parts of Georgia, and some in neighboring sections of Alabama and South Carolina, most of whom are happy to visit cases in their area and some who have

Approved by Professional Education Committee, Georgia Division, ACS.

CANCER PAGE / Continued

voluntarily travelled over the state to visit patients.

At the present time, information on the availability of laryngectomees throughout the state can best be obtained by contacting the president of the organization, Mr. Ray Holley, 1846 South Gordon Road, S.W., Atlanta, Georgia, or the American Cancer Society, 2025 Peachtree Road, N.E., Atlanta 9, Georgia. The Association is in the process of revising its roster and when it is completed, it can be distributed to all interested physicians throughout the state.

The Georgia Ileostomy and Colostomy Association

Georgia is one of the 17 states which has organized colostomy associations. The Georgia Ileostomy and Colostomy Association, Inc. was organized a few years ago and until the present time, it too has confined its activities primarily to the Atlanta area. This group can be contacted through its president, Mrs. C. N. Walker, 794 Laurelmont Drive, S.W., Atlanta, Georgia. One of the principal functions of this group also, has been to send selected members

of the organization to visit patients at their physicians's request. Their help with patients in obtaining the proper appliances and adhesives for the individual's particular situation, in ways to eliminate skin irritations and other practical solutions to problems has been very gratifying.

This group includes patients who have had surgery for benign lesions as well as malignant disease. Its publication, *The G. I. C. A. Osteomite*, is distributed to physicians without charge (although a \$1 per year subscription contribution would be happily acceptable to defray the cost of publication, presently being borne by the members).

The potential of these two groups for service to both the physician and patient is great. At the present time, the primary source of dissatisfaction has been, first, the failure on the part of physicians to use their help, and secondly, a need for information regarding the location of patients over the state in order to organize accessible groups in other localities. By utilizing their assistance and providing information to them, physicians in Georgia can enable these groups to fulfill their purpose.

HEALTH CARE OF THE AGED

THE BOARDS OF TRUSTEES of the American Hospital Association and the American Medical Association, in a joint resolution made public recently announced they will mobilize their full resources to accelerate the development of adequately financed health care programs for needy persons—especially the aged needy.

The resolution made it clear that both organizations will stimulate their state and local components to work with local government toward adequate financing of high quality health care for the needy supported by all community resources and necessary tax funds.

The resolution stated that provision of health care to "the indigent or near indigent is primarily a community responsibility," and made these points:

One: The Boards of Trustees recognize the effective medical care programs for needy persons already established in some states and local communities, but have taken this joint action because of their conviction that such programs deserve increased support and stimulation.

Two: Such proposals as the Forand bill are not designed especially to assist the needy, since they apply to all social security beneficiaries and exclude the majority of needy persons who are not eligible for social security benefits. (Under the Forand bill, sponsored by U. S. Rep. Aime Forand (D.-R.I.), some 16 million persons eligible for Social Security benefits—mostly those over 65—would be entitled to receive hos-

pital, surgical and nursing home treatment under a program run by the Federal government. Both the American Hospital Association and the American Medical Association oppose the bill.)

Commenting on the passage of the joint resolution, Dr. Russell A. Nelson, president of the American Hospital Association and director of the Johns Hopkins Hospital, Baltimore, said: "Full payment by states and local communities of the actual costs of care for the indigent and those of low income is still a rarity, although the responsibility of such payment is acknowledged.

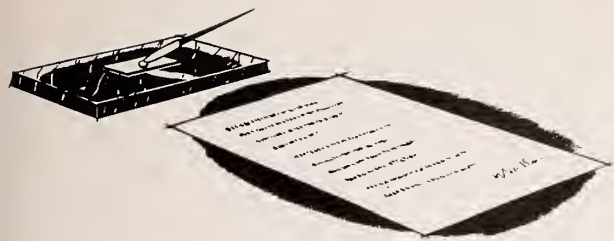
"Inadequate payment of high-cost care means that the costs of the care of the needy must be met by the paying patient, by cutting back needed expansion of hospital services, or by payment of insufficient salaries to hospital employees," Dr. Nelson said.

Dr. Louis M. Orr of Orlando, Florida, President of the American Medical Association, said: "The responsibility for taking care of the old person rests primarily with his family. If the family cannot fulfill this responsibility, then it passes to the community, and then to the state.

"We will do everything in our power to encourage local and state governments to fulfill this responsibility.

"Forand-type legislation would reduce the quality of medical care in this country. Such legislation is political medicine."

abstracts by georgia authors



Becker, Folke and Denny, Willis P., B.S., V.A. Hospital, Dublin, Georgia, "Abdominodiaphragmatic Breathing in Pulmonary Emphysema", South. M.J. 52:1225-1226 (Oct.) 59.

One hundred and twenty-three patients receiving instruction in abdominodiaphragmatic breathing in a two year period were studied to determine the reliability of vital capacity testing as an index of clinical improvement. It was found that vital capacity testing too frequently produced equivocal results to be a reliable guide in evaluating abdominodiaphragmatic breathing techniques. Activity tolerance, on the other hand, was a more useful objective guide in determining clinical improvement or lack thereof in patients undergoing instruction in abdominodiaphragmatic breathing techniques. One group of patients showing decrease in vital capacity actually demonstrated the same improvement in activity tolerance as a group showing a gain in vital capacity. In the opinion of the authors, there was very little direct relationship between vital capacity measurements and improvements in activity tolerance in the 123 patients studied.

Redd, Bryan L., Jr., Emory University School of Medicine, Atlanta 22, Georgia, "Lymphosarcoma of the Stomach", Am. J. Roentgenol. 82:634-650 (Oct.) 59.

Lymphosarcoma arising as a primary neoplasm in the stomach constitutes approximately one to three per cent of all malignant lesions arising in the stomach. Eight hundred thirty-four cases have been reported in the medical literature and an additional 13 cases are reported. The patients with lymphosarcoma of the stomach are generally in much better physical condition and younger than those with carcinoma of the stomach. Gastric acidity may be within normal values, the radiographic differentiation between carcinoma, lymphosarcoma and hypertrophic gastritis may be impossible. The diagnosis may be established by performing cytologic studies of material obtained by lavage or the use of the "balloon technique." Radical surgical removal is the treatment of choice. If non-resectable or incompletely removed, irradiation therapy is indicated. The five year survival rate ranges from ten to 66 per cent. Many of the five year survivors had incomplete removal of the primary lesion and/or metastasis controlled by irradiation therapy. The histology of

all gastric lesions should be established if possible because of the more favorable prognosis of primary lymphosarcoma of the stomach when adequately treated.

Brown, Harmon, and McGarity, W. C., Emory Hospital, Atlanta 22, Georgia, "Chronic Thyroiditis in Childhood", J.A.M.A. 171:1182-1186 (Oct. 31) 59.

Chronic thyroiditis is an unusual cause of goiter in children. Only 31 cases were found in the literature, in comparison with 334 cases of thyroid carcinoma collected by Winship.

An 11-year-old girl was seen with an eight-month history of goiter. She appeared euthyroid. The thyroid gland was bilaterally enlarged with nodules in both lower poles. Thyroid function studies were I^{131} uptake of 8.5 per cent in 24 hours, and PBI 3.2 micrograms per cent. Scintiscan showed no cold areas. At operation the thyroid was diffusely enlarged. The left lower pole and isthmus were removed. Histologic sections revealed chronic thyroiditis.

Most children with chronic thyroiditis are pre-pubertal females with a history of asymptomatic goiter for months to years. The thyroid gland is usually bilaterally enlarged, firm, and irregular. Function studies are usually normal, but in a few patients an elevated PBI and normal BEI (butanol extractable iodine) have been noted. Serum anti-thyroid antibodies have been demonstrated.

Surgical excision of a minimal amount of tissue, or needle biopsy, may be necessary for diagnosis.

Therapy with thyroid extract in dosage sufficient to maintain the PBI within normal range should be instituted. This will usually reduce the size of the goiter in three to six months. Surgery may be necessary later for cosmetic reasons or to relieve pressure.

Brown, W. J.; Sellers, T. F.; and Thomas, E. W., C.D.C. Public Health Service, Atlanta, Georgia, "Challenge to the Private Physician in the Epidemiology of Syphilis", J.A.M.A. 171:389-393 (Sept. 26) 59.

The authors present the current status of early syphilis control in the United States. The lack of reduction of the incidence of primary and secondary syphilis since 1954 is posed as a problem. Under-reporting of syphilis cases treated by private physicians and lack of adequate interviewing of infectious syphilis patients for sex contacts are suggested as the factors responsible for

the lack of further declines in the trend of infectious syphilis. Examples of private physician teamwork in syphilis epidemiology are given. Extension of such cooperative activities to other areas is urged. Statistical charts are included to depict graphically the major points of the text.

Letton, A. H. and Wilson, John Page, Georgia Baptist Hospital, Atlanta, Georgia, "Traumatic Severance of Pancreas Treated by Roux-Y Anastomosis", Surgery, Gynec. & Obst. 109:473-478 (Oct.) 59.

This article deals with the non-operative, common non-penetrating injuries of the pancreas and in particular the completely severed pancreas. The trauma which may cause such an injury may at times be insignificant with the symptomatology varying from very mild to severe, thereby making the diagnosis at times difficult. The opinion is expressed that after reading the reports of trauma in the literature, many of the post-traumatic pseudocysts are the result of this condition which went unrecognized at the time of injury. Two cases are reported in which a previously unreported technique of management employing closing the proximal fragment's severed end and anastomosing the distal fragment to the jejunum by Roux-Y technique was used. This technique in those two cases resulted in prompt recovery without any complications such as many times follow the usual methods of handling this condition. The technique as described in a definitive approach which should be applicable to severance of the pancreas whether due to blunt or penetrating trauma. Since it is definitive and specific, it should improve the results of treatment of this condition.

McClure, John N. Jr., 3451 Peachtree Road, Atlanta, 5, Georgia, "Power Lawn Mower Injuries are Preventable", South. M.J. 52:1254-1257 (Oct.) 59.

During the past several years there has been a tremendous increase in the manufacture and sale of power lawn mowers until there are now approximately 16 million in use. The yearly market is approximately 3½ million at the present time and 90 per cent of the mowers are rotary type. The number of injuries associated with the use of these machines has paralleled their sale. These injuries can cause loss of life, limb, eyesight, and other permanent disabilities. Most of the injuries are associated with the use of the rotary

ABSTRACTS / Continued

type mower and are due to carelessness on the part of the operator of the machine. However, some of the injuries are caused by poor design of the power and lack of proper guarding of the blades. In a survey made in cooperation with the Georgia Department of Public Health Accident Prevention Unit, 70 per cent of the injuries were found to be caused by direct contact with the power, whereas, 30 per cent of the injuries were caused by missiles being thrown by the mower. Among the missile type injuries, the eyes accounted for 16 per cent. Among all injuries, nine per cent developed complications and 14 per cent developed permanent disabilities. Illustrations of various types of injuries from the head, chest, abdomen, and extremities are shown.

In order to prevent more of these injuries, an extensive educational pro-

gram is suggested for the users of these machines. It is also suggested that manufacturers be more careful with the proper design of mowers, emphasizing safety features. Another suggestion also is that the reel type mowers are considerably safer than the rotary type mower. A simple method of preventing the missile injuries is to clean off the rocks, wires, stones, etc., from the area to be mowed.

Fish, John S.; Bartholomew, R. A.; Colvin, E. D.; Grimes, W. H., Jr.; Lester, W. M.; and Galloway, W. H., 272 Boulevard N.E., Atlanta 12, Georgia, "The Relationship of Pregnancy Weight Gain to Toxemia", *Am. J. Obst. & Gyn.* 78:743-754 (Oct.) 59.

Where usually accepted limits of normal weight gains in pregnancy were used, i.e., 25 pounds total gain, two pounds per week or six pounds per month short term gains, in an unselected group of 1000 patients 71

per cent were found to have gained excessively. In this group the toxemia rate was 1.6 per cent.

In a breakdown of this group, toxemia incidence among patients gaining over 35 pounds was 3.0 per cent, among those gaining over eight pounds in one month 2.5 per cent, and over three pounds in one week 2.7 per cent. Only in 45 patients with jump-gains of four pounds or more in one week did toxemia rates show significant rise to 9.0 per cent.

Among toxemic patients, 58 per cent gained over 25 pounds total while among normal controls, 45 per cent gained over 25 pounds total. Among toxemic patients, 48 per cent showed jump-gains of eight pounds in a month and 24 per cent showed jump-gains of four pounds or more in a week.

The authors conclude that excessive pregnancy weight gain and toxemia should be largely dissociated. Neither prognostically nor diagnostically is there a strong correlation.

BLUE SHIELD PROGRESS

THE NATIONWIDE BLUE SHIELD Plans and their sponsoring medical societies have registered outstanding progress in implementing the American Medical Association resolution—passed one year ago today—calling for the development of medical care coverage for the aged by voluntary means, John W. Castellucci, executive vice president of the National Association of Blue Shield Plans reported in Chicago recently.

"Only eight of the 67 Blue Shield Plans located in the United States, with only two per cent of total Blue Shield membership, have no programs for senior citizens in the works at the present time," he noted.

Castellucci said that the remaining 59 Plans either have special aged programs already being offered in their areas, or have programs in various stages of development.

Specifically, the study conducted by the national Blue Shield association showed that 32 of the Plans, representing more than 50 per cent of total enrollment, have made available nongroup programs for persons over the age of 65. Three Plans, with about 15 per cent of total Blue Shield membership, have programs already approved and ready to be offered as soon as the mechanics of administration are completed. Also, 23 additional Plans, covering 30 per cent of total enrollment, have senior citizen programs in various stages of development and these Plans report that they expect their programs to be in force early in 1960.

Thus, about 98 per cent of the total United States Blue Shield enrollment is in areas where special aged programs are already being offered or are in stages of

development, all within a one year period following passage of the AMA resolution.

Castellucci indicated that in the development of programs for senior citizens, the Plans have followed three general lines of approach: (1) developed new programs designed specifically for persons over 65; (2) effected modifications in existing programs to accommodate enrollees over 65; and (3) eliminated age limits on existing non-group programs offered to the general public who are not eligible to join through their place of employment.

Prior to the passage of the AMA resolution, the national Blue Shield organization noted, only a limited number of Plans had special programs for the aged, although all Plans traditionally imposed no age limit on group enrollment and permitted continuation of Blue Shield coverage to all members who had acquired it prior to reaching 65.

"While it is realized that the many and varied problems confronting our senior citizens cannot readily be solved in a short period of time, it is heartwarming to note the significant progress made by Blue Shield Plans throughout the country in the past year in developing programs to meet the special medical needs of persons over 65. In offering these programs Blue Shield, of course, is fully cognizant of the splendid cooperation offered by sponsoring medical societies without whose efforts such significant progress could not have possibly been recorded in 12 short months," Castellucci concluded.

DOCTORS AND MENTAL HEALTH

THE TREATMENT AND CARE of the mentally disturbed individual is primarily, of course, a medical problem. Until April, 1959, the doctors of Georgia, except for a few physicians directly employed by a civilian agency, had little or nothing to do with the public problems of mental illness in Georgia, in spite of many recommendations made over a period of 50 years.

Since 1959, however, the Medical Association of Georgia, either through committee action or by means of the efforts of individual physicians has taken on a great share of the responsibility for and guidance of the mental health program.

It is incumbent upon the doctors of Georgia, having taken on these grave responsibilities and duties, to do their part in seeing that the public attitude toward care, treatment, and rehabilitation of the mentally ill does not lapse into the state of apathy and indifference previously encountered.

All Georgia was shocked by the series of newspaper articles about the Milledgeville State Hospital appearing in March, 1959. Governor Vandiver characteristically met this challenge promptly and forcefully by asking the Medical Association of Georgia to appoint a committee to investigate the situation and to make recommendations. The "Schaefer Committee" was the result. Its report was masterful, accurate, and illuminating. Many of the recommendations of this report have been carried out, much to the present and future benefit of the mentally ill of Georgia.

The State Department of Public Health, headed by Dr. Sellers, Dr. Venable, and Dr. Stubbs has been assigned the responsibility of running the Milledgeville State Hospital and certain acute treatment centers in general hospitals.

The State Board of Public Health is composed mostly of physicians who are active in the Medical Association of Georgia, and who can be counted upon to see that the mental problems are dealt with in a manner medically acceptable.

In addition, Governor Vandiver has appointed an



Luther H. Wolff

LUTHER H. WOLFF, M.D.,

President, Medical Association of Georgia

PRESIDENT'S LETTER / Continued

Advisory Committee on Mental Institutions which has on its membership a preponderance of skilled psychiatrists and other physicians, as well as lay individuals who are intensely interested in the mentally ill. This committee, if kept functioning, will be of remarkable benefit in keeping the momentum of improvements going.

Dr. I. H. MacKinnon, a nationally known psychiatrist and administrator, has taken over as Superintendent of the Milledgeville Hospital and has already

inaugurated changes and improvements, with sound plans for future developments.

Lastly, it is a fact that the improvements so urgently required for the adequate care of our mentally ill, both from a physical and from a professional viewpoint, will require extensive appropriations by the legislature. I ask each member of the Medical Association of Georgia to urge his local member of the legislature to vote for the allotment of the necessary funds, even though it may require an increase in taxes somewhere along the line. This mental health program is a *must* for Georgia!

REPORT ON SIXTH ANNUAL CONFERENCE OF MENTAL HEALTH REPRESENTATIVES OF STATE MEDICAL ASSOCIATIONS

THE SIXTH ANNUAL CONFERENCE of Mental Health Representatives of State Medical Associations met at the Drake Hotel on November 20th and 21st in Chicago, Illinois. This conference is sponsored by the Council on Mental Health of the American Medical Association and for the first time, included the official representatives of State Mental Health Agencies.

The subject of this conference was "Organized Medicine in its Relationship to the Hospitalized Psychiatric Patient" which was broken into six areas: (1) State Hospitals; (2) Private Mental Hospitals; (3) General Hospitals; (4) Out-Patient Psychiatric Clinics; (5) General Rehabilitation Services, and (6) Medicolegal Aspects of Court Procedures Relating to the Mentally Ill.

It was an extremely rewarding experience, both in the stimulation received from the finest minds in the terms of the acquaintances made and renewed, and country. There was quite a few areas that were especially applicable to our local problems in Georgia, and I have enumerated a few of these below for the benefit of the MAG council.

The committee on organized medicine in its relationship to the hospitalized psychiatric patient in the State Hospitals, and other public mental hospital areas made some interesting observations that were especially pertinent to Georgia. This group deplored the "bigness" of mental hospitals which were located at distances from the communities they served; deplored the cumbersome procedures for admission of patients to the hospital and stressed the need for the local community to assume more responsibility for the care of its mentally ill. The legal impediments to the free flow of patients in and out of the state facilities must be overcome through proper legislation. This group stressed the importance of voluntary admissions and open wards. It urged strongly that not another building be erected to add more beds to a large public mental hospital; rather that new constructions should be designed to provide

community mental health centers and general hospital facilities for the psychiatric patient. It stressed the need to close the gap between organized medicine and the public mental hospital and urged conferences designed for such a purpose.

The group discussing the role of organized medicine in its relationship to the hospitalized psychiatric patient in a private mental hospital area expressed concern over the lack of private insurance support, especially Blue Cross, for private mental hospital patients. It stressed the importance of the private mental hospital in treating first admissions and noted that although private mental hospitals comprise only two per cent of psychiatric beds, they admit 40 per cent of all psychiatric first admissions yearly.

The group discussing the relationship of organized medicine to the hospitalized psychiatric patient in the general hospital areas discussed the tremendous role that the psychiatric service in general hospitals can play in diminishing public resistance to psychiatric treatment, thus furthering early diagnosis and care. The role of the general hospital psychiatric service in community education, as well as professional education, was discussed and the various problems involved in the administration of such a unit were considered in detail. This, of course, is an area in which we in Georgia, especially Atlanta, should be interested, since we are one of the largest metropolitan areas in the United States without a psychiatric bed in a general hospital. It was interesting that this fact is known and recognized by leaders throughout the country, and would appear to be an area for action by the Medical Association of Georgia's Committee in conjunction with the Fulton County Medical Society's Committee on Mental Health.

The group discussing the problems of organized medicine in its relationship to the hospitalized patient in the out-patient's psychiatric clinic areas is again

of particular importance to us in Georgia. Several of the groups urged increasing the number of mental hygiene clinics and the coverage of localities by these clinics. Their tremendous importance in terms of after care of recently discharged state hospital patients was stressed and is obvious. The fact that some chronically sick patients can be treated at home through such a clinic without resorting to the expense of state hospitalization and withdrawal from the community was stressed. The non-hospitalized indigent psychiatric patient is certainly a problem, and one that cannot in all probability be met entirely through university programs. The community in Georgia has not as yet decided to meet the cost of such care, although one wonders if it would not be cheaper than maintaining 12,000 patients in an institution such as Milledgeville.

The discussion group on general rehabilitation services expanded on the previous problems and stressed the need for communication between psychiatry and general practice. The return of the discharged patient to industry, and the need for continued contact between

the physician and the employer in helping the employer understand, and accept the discharged patient was discussed.

We in Georgia are going through a period of re-evaluation of our medicolegal aspects of commitment and discharge, and this group made many recommendations which are applicable to us. Again, the need for a meaningful method of authorizing voluntary admissions to state hospitals was emphasized. The need for provisions allowing for emergency admissions was stressed and the use of jails for detention was deplored. It was agreed that the state mental health laws should be more uniform and it was emphasized that in the preparation of proposed legislation, it is essential to proceed slowly with careful thought and planning.

I wish to thank the council for the opportunity of participating in this stimulating conference.

R. J. VAN DE WETERING, M.D., Chairman
Mental Health Committee
Medical Association of Georgia

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the association

ANNOUNCEMENTS

The Council on Postgraduate Medical Education of the American College of Chest Physicians will present the 13th Annual Postgraduate Course on Diseases of the Chest at the Sheraton Hotel, Philadelphia, March 14-18, 1960. Tuition for this five-day course will be \$100, including round table luncheon discussions. Further information may be obtained by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Ill.

The Gill Memorial Eye, Ear, and Throat Hospital announces to the profession its 33rd Annual Spring Congress in Ophthalmology and Otolaryngology, April 4-9, 1960. For further information write: Superintendent, P.O. Box 1789, Roanoke, Va.

Symposium on Hospital Management-Labor Union Relations, Wednesday to Friday, January 20-22, 1960, Hotel Waldorf-Astoria, New York. For further information write to: Hugh C. McEwan, President, American Academy of Medical Administrators, Suite 1134 at Eleven Beacon Street, Boston, Mass.

The Medical College of Georgia and Medical College of Georgia Foundation, Inc. present a short course in Obstetrical Complications in General Practice, March 15-17, 1960. Coordinator will be Dr. C. I. Bryans, Jr., Associate Clinical Professor and Acting Chairman of the Department of Obstetrics-Gynecology, Medical College of Georgia. Guests include Dr. John D. Thompson, Associate Professor of the Department of Obstetrics-Gynecology, Emory University and Dr. Laurence Hester, Chairman of the Department of Obstetrics-Gynecology, Univ. of S. C. Medical College. \$50.00 will be charged for the session. This course is acceptable for 18 hours credit, Category I, American Academy of General Practice. For additional information write: Dr. Claude-Starr Wright, Department of Continuing Education, Medical College of Georgia, Augusta, Ga.

The 1960 Annual Meeting of the Southern Trudeau Society (and the Southern Tuberculosis Conference) will be held on September 14-16, 1960, at the Hotel Francis Marion, Charleston, S. C. For further informa-

tion write to: Judson M. Allred, Jr., Sec.-Treas., P. O. Box 9865, Northside Station, Jackson, Miss.

The Division of Postgraduate Education, College of Medicine, University of Florida, Gainesville, Fla. and the Department of Anesthesiology, University of Miami School of Medicine, Miami, Fla. present a seminar in anesthesiology, February 4-6, 1960. This course is approved for Category I credit by the A.A.G.P. For further information write: Division of Postgraduate Education, College of Medicine, University of Florida, Gainesville, Fla.

Under the auspices of the Department of Pediatrics, the Division of Postgraduate Education, College of Medicine, University of Florida presents a seminar in pediatrics, February 11-13, 1960. This course is approved for Category I credit by the A.A.G.P. For further information write: Division of Postgraduate Education, College of Medicine, University of Florida, Gainesville, Fla.

Under the auspices of the Department of Obstetrics and Gynecology, the Division of Postgraduate Education, College of Medicine, University of Florida, presents a seminar in obstetrics and gynecology, February 25-27, 1960. This course is approved for Category I credit by A.A.G.P. For further information write: Division of Postgraduate Education, College of Medicine, University of Florida, Gainesville, Fla.

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its annual meeting at the Greenbrier Hotel, White Sulphur Springs, West Virginia, April 10-12, 1960. For any additional information, please contact the secretary, Dr. Albert C. Esposito, First Huntington National Bank Building, Huntington 1, West Va.

DEATHS

JEAN GEORGE BACHMANN, a leading Atlanta heart specialist and professor emeritus of physiology at

Emory University School of Medicine, died November 28 after a short illness.

From 1947 to 1953 Dr. Bachmann was associated with the Lowance Clinic as a consultant in cardiology. On Sept. 1, 1953, he was appointed medical director of the Georgian Clinic, a state hospital for the treatment of alcoholics. He served in that capacity for about two years.

A native of France, Dr. Bachmann became a naturalized American citizen in 1908 and received his medical degree at Jefferson Medical College, Philadelphia.

The author of a widely used textbook, "Essentials of Physiology and Pharmacodynamics" and of numerous articles in medical and scholarly journals, he was the discoverer of Bachmann's muscle bundle, a body structure of significance in the function of the heart.

Dr. Bachmann served as professor of physiology at Emory from 1915 until 1947, at which time he retired and was made professor emeritus. At the time of his death he was an honorary staff member of Emory Hospital.

He was a member of the American Physiological Society, the American College of Physicians, the American Association for the Advancement of Science, the Georgia Academy of Science, the New York Academy of Science, the American Heart Association, and was an honorary member of the Fulton County Medical Society.

Survivors include his wife; a daughter, Mrs. James Allgood, Yazoo City, Miss.; a brother, Albert Bachmann, Roslyn, Pa.; and a step-sister, Miss Emilienne de Lorme, Paris, France.

WILLIAM WARD BAXLEY, 55, of Macon, died suddenly November 14 in Athens.

Dr. Baxley was born in Richmond County and made his home in Macon after graduation from the Medical College of Georgia in Augusta in 1927.

He was a member of the Bibb County Medical Society, the Medical Association of Georgia, and the American Medical Association. He was a Fellow of the American College of Surgeons, a member of the Southeastern Congress of Surgeons, and past president of both the Macon and Parkview Hospital staffs.

Dr. Baxley served as a Steward of the Vineville Methodist Church and was a member of the Macon Kiwanis Club, the Idle Hour Country Club, and the Elks Club.

Survivors include his wife; two daughters, Mrs. William H. Chew, Jr., Little Rock, Ark., and Mrs. Cecil Neville, Jr., Chapel Hill, N. C.; one son, William Ward Baxley, Jr., a student at Emory University; one sister, Mrs. O. Q. Watson, Macon; and two brothers, Dr. Harry B. Baxley, Donaldsonville, and Dr. Warren C. Baxley, Blakely.

CHARLES GLENVILLE GIDDINGS, 68, a leading Atlanta physician for many years and assistant professor of medicine in the Emory University Medical School, died November 29.

Born in Atlanta, Dr. Giddings was a graduate of the University of Virginia Medical School and had practiced in Atlanta since World War I.

In 1936, Dr. Giddings won the Crawford W. Long medal for best original research for a paper read before the Medical Association of Georgia. He served as

governor of the American College of Physicians for several terms.

He was a member of the Methodist Church, Alpha Omega Alpha medical fraternity, the Rotary Club, the American Medical Association, the Medical Association of Georgia, the Southern Medical Association, and the Fulton County Medical Society.

Survivors include his wife; a daughter, Mrs. Matthew Connor, Atlanta; a son, Dr. Glenville A. Giddings, Atlanta; and a sister, Mrs. W. C. Caye, Highlands, N. C.

WILLIAM JACKSON HUTCHINS, who had practiced medicine and surgery at Buford since 1912, died November 12, unexpectedly at his home at the age of 72.

Dr. Hutchins was born in Barrow County and received his medical education at the old Atlanta College of Physicians and Surgeons, graduating in 1910.

The Hutchins Memorial Hospital in Buford, completed in 1948, is largely credited to the efforts of Dr. Hutchins and a son, Dr. Harry Hutchins of Buford.

He was a member of the Chattahoochee Medical Society, Medical Association of Georgia, American Medical Association, North Georgia Medical Association, and the Masons.

He was made a permanent member of the Association of Railroad Surgeons after performing surgery by lamp-light on an injured railroad man. He was also a member of the Buford Methodist Church.

Survivors include three sons, Dr. Harry Hutchins, Buford, J. Dorsey Hutchins, Winder, and John Hutchins, Atlanta; two sisters, Mrs. J. C. Pool, Winder, and Mrs. J. B. Williams, North Wilkesboro, N. C.; two brothers, H. W. Hutchins and R. E. Hutchins, both of Atlanta; and nine grandchildren.

JOB CALDWELL PATTERSON, 67, who had headed Patterson Hospital for the past 28 years, died unexpectedly November 8 at his home in Cuthbert.

Dr. Patterson was born and reared in Lumpkin.

He received his education in the Stewart County Public Schools and the Atlanta College of Physicians and Surgeons, now Emory University School of Medicine, from which he received the degree of Doctor of Medicine in 1913.

After World War I he studied at the D'Aix Medical School in Marseilles, France, and he did postgraduate work at the leading clinics throughout the United States, including Mayo Clinic, Lakey Clinic, and Ochsner Clinic.

He became associated with the late Dr. Frederick Davis Patterson, Sr., founder of Patterson Hospital, in 1919, becoming head of the institution on the death of Dr. Frederick Patterson in 1931.

Dr. Patterson served as president of the Medical Association of Georgia in 1940-41. He had served as a member of the City Council of Cuthbert, as president of the Cuthbert Rotary Club, as president of the Randolph-Terrell Medical Society, the Third District Medical Society, and the Georgia Chapter of the American College of Surgeons. At the time of his death he was a Fellow in the American College of Surgeon and the International College of Surgeons. He was Randolph County Physician and a member of the Randolph County Board of Health, was serving on the Board of Directors

the association CONTINUED

of Blue Shield of Georgia, was a Trustee of Andrew College, a Director of the Citizens Bank of Cuthbert, and the Randolph County Federal Savings and Loan Association. He was local surgeon for the Central of Georgia Railway Company, and the Seaboard Air Line Railway Company. He was a Mason, a Shriner, a member of the American Legion, the Phi Chi Medical Fraternity, and the Cuthbert Rotary Club.

He served as a Major in World War I, acting as Director of Field Hospitals of the 31st Division in France.

Survivors include his wife; one daughter, Mrs. R. G. Puckett, Shellman; three grandchildren, Patricia, William Robert, and Elizabeth Ann Puckett, Shellman; a sister, Mrs. Sam Gatewood, Richland; a brother, C. Humber Patterson, Atlanta; his step-mother, Mrs. John T. Patterson, Lumpkin; and several nieces and nephews.

EDWARD McMICHAL WEST of Atlanta died suddenly at the age of 38 November 13.

Dr. West was a graduate of old Boys High School, Emory University, and the Medical College of Georgia. He interned at Grady Hospital and later became a staff physician.

He was a member of St. Luke's Episcopal Church, Atlanta Gun Club, Fulton County Medical Society, Medical Association of Georgia, and the American Medical Association. He was also a member of the Georgia Historical Society and had a large collection of postage stamps of historic interest.

Survivors include his wife; two sons, Carroll Mulkey and Michael Palmer West; and his mother, Mrs. C. M. West, all of Atlanta.

SOCIETIES

Dr. Louis M. Orr of Orlando, Florida, president of the American Medical Association, spoke at Cumming at a special dinner meeting of the CHATTAHOOCHEE MEDICAL SOCIETY recently.

The COLQUITT COUNTY MEDICAL SOCIETY, following a recommendation made by the American College of Chest Physicians, has appointed a medical tuberculosis committee to cooperate with the Colquitt County Tuberculosis Association. At one of their recent meetings, Dr. John T. Greene, member of the faculty of Florida State University, spoke on marriage counseling.

The DEKALB COUNTY MEDICAL SOCIETY, at its recent meeting passed a resolution approving the National Epidemiological Study about to be launched by the American Cancer Society in 25 states, including Georgia. Their recent meeting was held jointly with the Woman's Auxiliary to the DeKalb County Medical Society at the Decatur Elks Lodge.

Some 250 persons heard heart experts, all former presidents of the Georgia Heart Association, discuss new concepts in heart disease at a public forum recently at the Academy of Medicine. The GHA and the



Marcus Mashburn, Cumming; Dr. and Mrs. Louis M. Orr, Orlando, Fla.; and D. C. Kelly during special dinner meeting of the Chattahoochee Medical Society.

FULTON COUNTY MEDICAL SOCIETY sponsored the forum.

Each year the FULTON COUNTY MEDICAL SOCIETY presents the Aven Award to an Atlanta physician for outstanding civic service to the community. The public has been asked to help in nominating doctors for the award.

J. G. McDaniel was nominated president-elect of the FULTON COUNTY MEDICAL SOCIETY recently. J. D. Martin, Jr. will be installed as their new president at their next meeting. Others nominated for 1960 officers included William Moore, vice president, and Thomas J. Anderson, Jr., secretary-treasurer.

The GEORGIA MEDICAL SOCIETY held its regular business meeting recently with no scientific program at this meeting.

MUSCOGEE MEDICAL SOCIETY recently installed Simone Brocato as 1960 president and elected Edgar Horn president-elect. Meeting at the Standard Club in Columbus, the area physicians also installed Bruce Newsome as Society secretary and treasurer and Jack McGee as a member of the board of censors.

Recent results of the election of officers of the RICHMOND COUNTY MEDICAL SOCIETY are as follows: president, Jack Waters; president-elect, John Bowen; vice president, Preston Ellington; secretary-treasurer, F. N. Harrison; councilor to the Medical Association of Georgia, William Fuller; vice councilor, Pomeroy Nichols; delegates to the Medical Association of Georgia, Jack Waters and F. N. Harrison; and alternate delegates, Robert Ellison and John Fair.

The SOUTHEAST GEORGIA MEDICAL SOCIETY recently endorsed the research survey that the American Cancer Society will be conducting in Toombs County over the next few weeks.

At the regular meeting of the SOUTHWEST GEORGIA MEDICAL SOCIETY held in Fort Gaines recently, the following officers were elected for 1960: president, Homer Woods, Fort Gaines; vice-president, David Weatherby, Fort Gaines; secretary-treasurer, J. B. Martin, Edison; board of censors 1960, Warren Baxley, 1961, Hinton Merritt, 1962, Turner Aentz; delegate to the Medical Association of Georgia for the term 1960 through 1963, J. B. Martin, Edison.

alternate delegate, Turner Rentz, Colquitt.

The Christmas meeting of the THOMAS-BROOKS MEDICAL SOCIETY was held recently at the Archbold Memorial Hospital in Thomasville. The scientific program was presented by Dr. Herbert R. Karp, Associate Professor of Medicine, Emory University School of Medicine, Atlanta and Dr. Denton A. Cooley, Associate Professor of Surgery, Baylor University School of Medicine, Houston, Texas.

The UPSON COUNTY MEDICAL SOCIETY has set aside three special days to give Salk Vaccine polio immunization shots at reduced rates.

The WARE COUNTY MEDICAL SOCIETY heard a discussion of insurance problems at their regular meeting recently.

The SIXTH DISTRICT MEDICAL SOCIETY held its regular meeting recently at the Macon Hospital.

PERSONALS

First District

C. F. HOLTON, from Savannah, who for 14 years was chief surgeon at the Central of Georgia Railway Hospital, retired from his railway duties recently.

Second District

GEORGE DILLINGER, Thomasville, told Cairo Rotarians recently of the Georgia Heart Association's statewide program in the field of Stroke Rehabilitation.

H. EDWIN ADERHOLT, Tifton, has been elected chief of the Tift County Hospital medical staff, succeeding E. M. FLOWERS, also of Tifton.

ERNEST F. WAHL of Thomasville, recently spoke to the Thomasville Exchange Club on heart disease.

JOHN B. MORTON, Thomasville, recently was made a Diplomate of the American Board of Pediatrics.

Third District

LEONARD T. MAHOLICK, medical director of the Bradley Center, Inc. in Columbus, recently attended a three-day workshop on Mental Health Research, sponsored by the Southern Regional Education Board in Atlanta.

J. C. SERRATO, Columbus, recently spoke to the Third District of the Georgia State Licensed Practical Nurses Association on the "Bone and Pin Therapy."

Fourth District

WM. G. DUNBAR has moved to Hampton and opened offices for general practice at the Hampton Clinic.

JOSEPH F. KRAFKA, LaGrange, recently showed the LaGrange Lions Club colored slides of organs obtained through autopsies to show structural and functional changes caused by disease.

The Upson County Hospital Auxiliary held its regular meeting recently with HERBERT D. TYLER of Thomaston as guest speaker.

GEORGE WALKER of Griffin recently gave a very interesting discussion on heart disease at the Pike County Lions Club meeting.

Fifth District

JACK C. NORRIS of Atlanta was recently elected second vice president of the Southern Medical Association.

The Woman's Auxiliary to the Upson County Medical Society held its regular meeting recently with JOHN S. ATWATER of Atlanta as the featured speaker.

RIVES CHALMERS of Atlanta appeared before the Toccoa-Stephens County Association for Mental Health recently as guest speaker.

HAROLD LEVIN and HERBERT ALDEN of Atlanta presented a paper at the International Symposium on Griseofulvin and Dermatomycoses sponsored by the University of Miami held in Miami, Florida.

Sixth District

W. P. ROCHE, JR. of Dublin has been appointed a consultant at the Veterans Administration Center in Dublin.

Seventh District

R. L. DENNEY of Carrollton has been elected as chief-of-staff of the Tanner Memorial staff to serve for the coming year. Other officers elected for the 1959-1960 term were: HAROLD L. McLENDON, vice-chief-of-staff; J. HARVEY BEALL, secretary-treasurer; TOM REEVE, chief of surgery; W. STEVE WORTHY, chief of obstetrics and gynecology; E. V. PATRICK, chief of medicine; E. C. BASS, chief of pediatrics; D. S. REESE, chief of eye, ears, nose, and throat; and PHIL C. ASTIN, chief of scientific services. All are from Carrollton.

Eighth District

The biography of HERMAN DISMUKE of Ocilla is to be included in the 1960 edition of "American Men of Medicine," the third volume of "Who's Important in Medicine."

JOHN A. HIGHTOWER, ERWIN R. JENNINGS, and WOODROW W. PAYNE all of Brunswick have been accepted as staff members of the new Wayne Memorial Hospital.

VILDA SHUMAN of Waycross made her official visit to the Gainesville Pilot Club recently.

Ninth District

A. FREDERICK BLOODWORTH of Gainesville attended the meeting of the Southern Chapter of the American College of Chest Physicians held in Augusta recently.

Tenth District

J. D. GRAY, clinical professor of the Medical College of Georgia, Augusta, spoke briefly on the heart attack and the affects of the heart attack to the Thomson Lions Club recently.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE EXECUTIVE COMMITTEE OF the Council of the Medical Association of Georgia was called to order by Chairman Luther

Wolff at 10:15 A.M., November 15, 1959, at the Dinkler Plaza Hotel, Atlanta, Georgia.

Members of the Executive Committee present included: Luther H. Wolff, Columbus, President; Milford B. Hatcher, Macon; Chris J. McLoughlin, Atlanta, Secretary; J. G. McDaniel, Atlanta, Chairman of Council; and Virgil Williams, Griffin, Chairman of Finance.

Guests present at this meeting included: Messrs. Francis Shackelford and John Moore, Atlanta, MAG Attorneys; Mr. John Arndt, MAG Medicare Administrator, and Mr. M. D. Krueger, MAG Executive Secretary.

Chairman Wolff called on Mr. M. D. Krueger who reviewed the minutes of the October 10-11, 1959 Council of the Medical Association of Georgia meeting. Mr. Krueger then read the Executive Committee of Council meeting minutes of October 11, 1959 which, on motion duly made and seconded, were approved.

Life of Georgia Insurance Plan for MAG

Chairman Wolff called on Dr. Hatcher who discussed certain questions concerning the new MAG Life of Georgia Insurance Program. On motion (McDaniel-Hatcher) it was voted that President Wolff present certain questions to Dr. David R. Thomas, Chairman of the MAG Insurance and Economics Committee with the request that Dr. Thomas clarify these questions with the Life of Georgia Insurance Company and, further, that upon clarification of these questions, Dr. Thomas compose a letter of further explanation to the membership about the new plan and this letter be mailed to the membership by the Life Insurance Company of Georgia.

MAG Property Encroachment

MAG Attorney Mr. Francis Shackelford discussed the problem of encroachment on the proposed MAG property at 938 Peachtree Street, N.W., new MAG Headquarters Office Building by the owners of the lot adjacent to the MAG property. After discussion, it was moved (Hatcher-Williams) and voted to authorize Mr. Shackelford to contact the owners of the adjacent property and discuss this matter with them in full seeking a solution to the problem and further requesting Mr. Shackelford to report back on the progress at the December 13 Council meeting.

Cultists Problems

MAG Attorneys Mr. Francis Shackelford and Mr. John Moore discussed the problem and procedure in advising County Medical Societies about healing arts cultists practicing medicine in an unauthorized and illegal manner. Mr. Shackelford emphasized that the State Medical Association should provide advice and a guide of action for County Societies. Specific cases were discussed and this report was received for information.

Finance Committee Report

Finance Committee Chairman Virgil Williams reported on the income and expenditures of the Association and by general agreement, this report was accepted for information. Dr. Williams then stated that the Contingent Fund had been exhausted by Council approved expenditures and, on motion duly made and seconded, it was voted to recommend to the Council of the Medical Association of Georgia at their December 13 meeting



President Wolff; J. G. McDaniel, Atlanta; George Dillinger, Thomasville; and other members of Council and their wives enjoy choral group in Valdosta.

that \$5,000.00 be taken from the reserve fund and placed in the Contingent Fund.

Medicare Contract Renewal Option

Mr. John Arndt, Medicare Administrator, reported that the present MAG-Department of the Army Medicare Contract should be reviewed by the Executive Committee of Council at this time for consideration of the renewal of the contract for February, 1960. After discussion, it was moved and voted (McLoughlin-Williams) that the Executive Committee recommend to Council that the Association maintain its Medicare contract under the present system. Mr. Arndt then announced his resignation effective January 1, 1960 and discussed plans for his replacement with the members of Executive Committee. He was authorized by Executive Committee to proceed with these plans and was commended for his activity during his term of employment as Medicare Administrator.

New MAG Headquarters Office Building Report

Secretary McLoughlin reported on plans for the occupancy of the new MAG Headquarters Office building. Dr. McLoughlin explained an "office systems survey" proposed by the firm of Shaw-Walker. Dr. McLoughlin and Mr. Krueger recommended to Executive Committee that such a survey be undertaken by the firm of Shaw-Walker to improve the present and future efficiency in conducting business of the Association by the Headquarters Office Staff. On motion duly made and seconded it was voted to use the present budget for the undertaking of such a survey and further, that Executive Committee of Council recommends to Council the appropriation of additional funds for the completion of such a survey.

MAG-AMA Resolution

Secretary McLoughlin read a resolution proposed by Eustace Allen, MAG delegate for instruction at the AMA Dallas meeting. The resolution concerned the proposing of a course of study on the socio-economic aspects of the practice of medicine to be included in the curriculum for medical school students by medical schools. The resolution was discussed and it was recommended that Secretary McLoughlin review this resolution with Dr. Allen and report to Dr. Allen the discussion of Executive Committee on this resolution.

There being no further business, the meeting was adjourned at 12:20. P.M.

**Plan Now to Attend the
Annual Session
of the
Medical Association of Georgia**

May 1-4, 1960

Columbus, Georgia

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COVER

Cover illustration depicts the evolution of coronary artery disease ending with thrombosis, occlusion, and myocardial infarction. Elements of illustration courtesy of the Georgia Heart Association.

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SURGICAL TREATMENT OF OCCLUSIVE VASCULAR DISEASE OF THE EXTREMITIES

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The sine qua non for carrying out direct arterial surgery for occlusive vascular disease is the clinical or arteriographic demonstration of a good distal vascular tree.

OCCLUSIVE VASCULAR DISEASE WITH its resultant ischemia of an organ or part is beyond any question one of the most important causes of illness, suffering, and loss of life and limb with which the medical profession is faced today. It is trite to point out that the relative control of infectious diseases and the ever increasing standard of living have contributed to this immensely by increasing the average life span into the time of life where vascular occlusion is prevalent. Already today you have heard a discussion of the role of vascular occlusion in the production of stroke. The relationship of obstruction of the renal vessels to hypertension is also well known⁸. The syndrome of acute mesenteric artery occlusion is of course well recognized while the symptoms from chronic obstruction of the same vessel are less well known¹. These subjects are beyond the scope of this presentation, however. This discussion will deal with occlusion of the arterial blood supply as it affects the extremities.

The causes of obstruction to the arterial supply of the extremities are several. Buerger's disease and the other arteritides, trauma, extrinsic compression, embolism, and arteriosclerosis with or without thrombosis all play a part.

Buerger's disease, of late denied by some as existing as an entity separate from arteriosclerosis⁹, presents the picture of localized ischemia due to occlusion of terminal vessels¹⁰. Pain, cyanosis, and tenderness of the fingers or toes in the presence of good pulses at the wrist or ankle is the common picture seen here. Arteriograms rarely need to be done for confirmation of diagnosis, but when done they do show abrupt blockage of the small vessels. In the usual patient with Buerger's disease there is no evidence of generalized arteriosclerosis, a marked contrast to, say, the diabetic who has arteriosclerotic occlusion of the small vessels of the foot and has a gangrenous toe while having a good pulse in the foot. In our experience, lumbar sympathectomy has proved very helpful in the true Buerger's disease, while it is occasionally helpful in the arteriosclerotic terminal of vascular occlusion. Luetic arteritis and the non-specific arteritis of Takayashu¹¹, when they present as obstructive disease, pose a problem similar to arteriosclerosis.

Extrinsic compression, of course, is rare^{2,3}.

Trauma, a relatively common cause of arterial obstruction in war time, has come to be of ever increasing importance as the number of automobile accidents has continued to increase. Direct avulsion of vessels, or laceration by sharp bone fragments of

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adjacent fractures must constantly be thought of. Gunshot and stab wounds in the non-military battle-grounds common to every Southern city also take their toll. The prompt recognition of traumatic vascular occlusion depends on the awareness of its possibility and the routine examination for the presence of all peripheral pulses. To be successful, treatment must be prompt. While division of a major artery in the upper extremity may be adequately compensated for by existing collateral vessels, this is usually not true in the lower extremity. Here division of the main vessel, often with accompanying damage to the usual collateral arterial supply, leads to stagnation of blood flow in the distal vessels. Thromboses occur in the small vessels distally in an increasing amount with passage of time. After several hours have passed, large areas of muscle and skin may be rendered ischemic by such thromboses in spite of reconstitution of the main arterial vessel. For this reason, prompt anastomosis or replacement by graft to restore arterial continuity is necessary if one is to salvage a significant percentage of such extremities. Ligation of a major artery except under unusual circumstances can no longer be accepted as proper therapy for traumatic arterial obstruction^{4,26}.

Prompt Treatment of Embolism

The same need for prompt recognition and treatment is well recognized in the presence of embolism, whether it be spontaneous embolism from the heart or one of the great vessels, or whether it be an embolus occasioned by cardiac or arterial surgery. Here the resultant vascular spasm, both of the main vessel and of the collaterals, leads to severe insufficiency of flow distally with a similar

chain of pathologic events to those described above. Immediate heparinization of the patient will halt the progress of this chain of events while the operating room is being prepared. It is this vascular spasm with resultant severe ischemia which serves to differentiate embolism from the less dramatic arterial occlusion due to thrombosis occurring in previously diseased atherosclerotic vessels. An additional useful clinical differentiation may be made on the basis of the difference in the usual site of occurrence of the two processes. The abrupt cessation of arterial pulse at the point of major bifurcation in the groin or in the popliteal fossa usually indicates embolus, whereas the presence of a femoral pulse in the thigh above and not below the adductor hiatus indicates thrombosis¹². Embolectomy, when performed within the first few hours after the accident, is highly successful in restoring arterial flow. When distal propagation of thrombus has occurred, usually in the presence of some delay in therapy, we have occasionally found it very useful to expose and enter the distal vessels, frequently being able to flush out thrombus material from below with saline irrigated through ureteral or rubber catheters.

**Cause of Majority of Arterial
Occlusions**

Arteriosclerosis, of course, provides the cause for the great majority of arterial occlusions. Despite the intensive investigative work which is currently being carried out in an effort to discover the causes of atherosclerosis and to establish methods for its prevention⁵, it is clear that atherosclerotic obstructive vascular disease promises to be with us throughout the greater part of the practicing careers of almost all of us here. For this reason a close look at some of the therapeutic possibilities in the presence of this disease is in order. The literature of the last two or three years is literally crammed full of statistics related to surgical treatment of occlusive vascular disease of the extremities¹⁷⁻²⁵. Rather than bore this audience with yet another statistical survey, it is our intention to stress practical considerations in the management of those patients, and to present our material and results in tabloid form for the printed paper.

In considering a patient for surgical therapy of obliterative arteriosclerosis, it is well to remember that the disease process is a generalized one which is simply involving one area of the vascular tree more than the rest. Since manifestations of arteriosclerosis elsewhere account for a large percentage of the mortality associated with direct arterial surgery for this disease, it is well to carefully evaluate

TABLE I
Direct Arterial Surgery for Obstructive Arteriosclerosis

Site of Obstruction	No. of Patients	Operative Procedure	No. of Early Failures		No. of Late Closures		Hospital Deaths
Femoro-popliteal	22	Bypass Graft Endarterectomy	9	3	3	0	
			19	2	4	1	
Aorto-iliac	15	Bypass Graft Endarterectomy	4	0	0	1	
			11	0	0	1	
Subclavian	1	Endarterectomy	1	0	0	0	
TOTAL	34*	Bypass Graft Endarterectomy	13	3	3	1	
			31	2	4	2	

* 3 patients had bilateral femoral occlusions operated upon.
3 patients had one femoral artery reoperated upon after closure.
3 patients had aorta-iliac operation plus one femoro-popliteal operation.
1 patient had subclavian plus aorto-iliac operation,

the coronary, cerebral, and renal vessels by history, physical examination, and appropriate laboratory studies. A careful historical review of the cardiovascular system and an electrocardiogram, auscultation, and palpation of the carotid arteries plus a historical search for the "small stroke syndrome" and determination of the blood urea nitrogen or NPN are routine parts of our work-up. The amazingly high incidence of diabetes in this group of patients demands an assay of the fasting blood sugar, which if slightly elevated is further investigated by a glucose tolerance test. Forearmed and, hence, forewarned as the result of these investigations, one can then intelligently proceed to a choice of proper therapy. On occasions it may be wisest to withhold surgical therapy for occlusive disease of the extremities in the face of diffuse, severe atherosclerosis involving the other systems. More frequently it may be deferred to surgical therapy indicated more urgently elsewhere in the vascular tree. The clear superiority of the surgical approach to obstructive vascular disease involving the lower extremities over the nonoperative methods indicates its use except under the above circumstances^{15,16,13}. Since the onset of symptoms from arteriosclerotic obstruction of the vessels to the lower extremities by no means indicates a fatal outcome within the immediate or even near future^{6,15}, then measures which provide significant and lasting benefit are referable to and are chosen above those which provide less satisfactory results, even though some additional risks may be incurred. Hence direct arterial surgery, when it is able to be employed, is infinitely preferable to sympathectomy or other indirect surgical procedures to increase blood flow.

Principle Governing Direct Arterial Surgery

The cardinal principle governing the success or failure of direct arterial surgery for obstructive disease in any artery is the condition of the vessel distal to the point of obstruction. The immediate success or failure of the procedure regardless of the technical method employed, once the technical ability of the surgeon is established, depends in large measure on the ability of the distal vessel to receive and to disburse a large flow of blood. The length of the occluded segment and the level of the occluded segment in the vascular tree, while important in the long term result, have played no significant part in determining the immediate success or failure of the procedure in our experience. Furthermore, we have found that the choice of operative approach, whether to put in a graft or to carry out endarterectomy, similarly has little to do with the immediate result. The type of material used for a graft is likewise of

relatively little importance. Our *sine qua non* for carrying out direct arterial surgery for occlusive vascular disease is the clinical or arteriographic demonstration of a good distal vascular tree. The level of obstruction can in almost every instance readily be determined by palpating for the aortic, femoral, popliteal, and pedal pulses. When the obstruction is in the femoral artery, the arteriogram is made by injecting dye into the common femoral artery above the site of obstruction, allowing the collateral vessels to carry the medium into the distal vessel if it exists. Our routine is to inject five cc.'s of 50 per cent Hypaque® rapidly and then inject two cc.'s per second for the next eight seconds, and then inject five cc.'s rapidly, making the exposure as the last rapid injection is made. We have found this to give uniformly satisfactory arteriograms. When the obstruction is in the aortoiliac region we carry out arteriograms only if pedal pulses are absent. We are insistent on knowing the condition of the femoral artery because there is a significant incidence of coincident femoropopliteal obstruction. If the femoral pulse can be felt faintly beating, a femoral arteriogram can almost always be made in the usual fashion. If the femoral pulse cannot be felt, the first stage of the operative procedure is exploration of the common femoral artery to determine its patency and the patency of its superficial and deep branches. Arteriograms of the distal femoral vessel are usually carried out at this time. We do not feel it is necessary to do aortography, for if the patient is alive his aorta is patent at the level of the renal arteries. If one can demonstrate patency of the distal vessels, it is always possible to establish flow between the aorta and the distal vessel either by a graft or by endarterectomy or by a combination. We are always prepared to deal with an aneurysm should thrombosis within such be the cause of the occlusion. We feel then that aortography, which especially in the presence of distal obstruction carries a significant mortality and morbidity^{7,14} has little or nothing to offer to justify this risk. We feel most strongly that aortography for the demonstration of atherosclerotic plaques in the aortoiliac region which are not at present causing diminution of the distal pulses, but which may in the future obstruct, is unwise. We cannot hold with the concept of prophylactic surgery for such disease when the natural rate of progression of the disease is so vari-

TABLE II
Early Failures

Operative Procedure	No.	Cause of Failure	No.
Bypass Graft	3	Insufficient distal runoff	3
Endarterectomy	2	Insufficient distal runoff	1
		Technical accident	1

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able and the long term results of surgery yet so uncertain.

With regard to the choice of operative procedure, our early experience with the long term results of bypass grafts has lead us to choose thrombo-endarterectomy as the routine procedure in dealing with the femoral and popliteal vessels. As you will see in the analysis of our results, a long term follow-up here has been quite satisfactory. For aortoiliac obstruction, we have again tended to use thrombo-endarterectomy as the routine procedure, but in view of the excellent long term results in this region reported by the majority of workers from either method^{17,18} we have frequently used bypass grafts when the patient was large and obese with a deep pelvis, making the iliac vessels difficult to deal with directly.

Technique for Endarterectomy

Our technique for endarterectomy differs somewhat from the usual methods employing wire loops for stripping out the intima. The essential features of the technique involve exposing the entire length of artery which is occluded. In the abdomen this is accomplished by a midline incision, and in the leg by a long incision generally following the course of the sartorius muscle. Multiple short arteriotomies are made, the lowest over the distal end of the obstructive process and the proximal one near the proximal end. A plane is developed within the media of the vessel with a staphylorrhaphy dissector or a similar instrument. Thus the block of thickened intima and thrombus is freed and is lifted out through one of the arteriotomies. Care is taken to tack the free edge of the distal intima, which is often moderately thickened, to the vessel wall with interrupted mattress sutures. This is to prevent its being lifted away and folded in by the onrushing blood stream with ultimate obstruction to flow. The arteriotomies are closed with continuous 5-0 silk. Heparin is used liberally in the distal vessel during occlusion. The vessels are flushed from above and below before closing the arteriotomies, in order to wash out small clots or atheromata. On removal of the occluding

TABLE III
Late Closures

Operative Procedure	Duration patency	Cause of closure	Successful reoperation	Reclosure
Bypass Graft	1½ mo.	Thrombosis	Yes	No
Bypass Graft	7½ mo.	Thrombosis	Not tried	----
Bypass Graft	10 mo.	Thrombosis	Not tried	----
Endarterectomy	4 mo.	Thrombosis	Not needed	----
Endarterectomy	8 mo.	Thrombosis	Not needed	----
Endarterectomy	7 mo.	Thrombosis	Yes	No
Endarterectomy	12 mo.	S.B.E.	Yes	No

TABLE IV
Hospital Mortality

Cause of death	When	Remarks
Acute Coronary Insufficiency	Operative death	Previous Beck I operation for angina. Cardiac arrest. Uncomplicated course. Cardiac arrest during night. Post mortem done—coronary narrowing.
Acute Coronary Insufficiency	8th p.o. day	
Acute Coronary Thrombosis	10th p.o. day	Death following amputation after "desperation" femoral endarterectomy.

clamps, having the entire operated segment of vessel exposed allows one to be perfectly certain of good flow throughout, or to immediately determine and remedy why not.

An analysis of our material and results is set forth in the accompanying tables. In brief, 34 patients with obstructive arteriosclerosis have been subjected to 44 operative procedures. Our early results with bypass grafts were poor in the femoro-popliteal region, and we were led away from this approach for primary therapy. This may have been in part due to the materials used for the grafts, they being either crimped nylon or homografts. Our persistence at present in using endarterectomy as the procedure of choice is due largely to the fact that no patient has as yet lost an extremity due to late closure of an endarterectomized vessel. The period of follow-up is one to 30 months.

Summary

Occlusive disease of the vessels to the extremities may be of several causes, of which trauma supplies many and arteriosclerosis the majority of cases. Prompt recognition and treatment of traumatic obstructions by reconstitution of the vessel is imperative. Certain practical aspects of the management of patients with arteriosclerotic obstructions are discussed. Endarterectomy is preferred as the method of choice in surgery for arteriosclerotic obstruction. A tabloid summary of material and results is presented.

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SOURCE BOOK OF HEALTH INSURANCE DATA

THE AMERICAN PUBLIC SPENT an average of \$95 a person for medical care in 1958, the Health Insurance Institute reported recently in its new publication, "Source Book of Health Insurance Data."

Total public expenditures for personal medical care in 1958 were \$16.7 billion, comprising nearly six per cent of the public's outlay for all its personal needs.

Hospitals accounted for \$4.5 billion of the total, doctors for \$4.8 billion, dentists for \$1.7 billion, drugs, medicines, and orthopedic appliances for \$4.4 billion. The remaining \$1.3 billion went for all other medical costs, including private duty nurses, nursing homes, chiropractors, eyeglasses, and the expenses of acquiring health insurance.

The Source Book, first of its kind in the health insurance field, is a comprehensive compilation of statistical and other factual material related to health insurance and the financing of medical care. The information was drawn from several insurance associations, other health insuring plans, government agencies, as well as hospital and medical groups.

The 80-page book contains 11 charts, 32 tables, a glossary of health insurance terminology, and a list of historic dates in the health insurance field.

Some of the subjects relating to health insurance in the book are health insurance during 1958, extent of insurance coverage, trends in premiums and benefits, types of health insuring organizations, medical care costs, and morbidity in the United States.

The book notes that:

—More than 123 million Americans had health insurance at the end of 1958.

—Insurance companies covered 72 million persons, Blue Cross-Blue Shield 55 million, and independent plans five million. Some persons were insured by more than one organization and when allowance was made

for this duplication, the net total covered was 12 million persons.

—Ninety-one per cent of the 123 million persons who had hospital expense insurance also had protection against the costs of surgery.

—Eleven states had more than 75 per cent of their population insured, 29 states ranged between 50 per cent and 75 per cent, and 10 states were under 50 per cent. The leading state was New York with 90.5 per cent coverage.

—American families are budgeting more of their income toward the purchase of health insurance. In 1958, 1.9 per cent of the public's disposable personal income went for health insurance, compared to 1.5 per cent in 1954, and 0.8 per cent in 1949.

—The total amount of premiums paid to insurance companies, Blue Cross-Blue Shield, and other hospital-medical plans in 1958 was \$5.9 million.

—Health insurance benefit payments totaled \$4.7 billion in 1958, almost five times the amount of benefits paid in 1949.

—More than 1,200 insuring organizations provided the American public with health insurance in 1958, including 706 insurance companies, 83 Blue Cross and 66 Blue Shield plans, and more than 400 other plans.

—Nearly 22 million persons, one out of every eight in the U. S., were admitted to short-term general hospitals in 1958.

—There were 451,000 persons confined to hospitals on an average day in 1958.

—Men were more injury prone than women. During the year, the injury rates were 331 injuries per 1,000 men compared to 299 per 1,000 women.

—The American home accounted for the greatest percentage of injuries with 41 per cent of the persons injured victims of home accidents.

ORGANIC PSYCHOSIS AS PICKED UP IN PSYCHIATRIC EXAMINATION

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Introduction

THIS PAPER PRESENTS a study of those symptoms which are helpful in distinguishing organic from functional psychoses. This type of differential diagnosis confronts almost all physicians and is sometimes quite difficult. The difficulty is amply demonstrated by the number of patients who are referred to psychiatrists with a diagnosis of functional psychosis and are found to have organic brain disease. The competent psychiatrist maintains a healthy doubt of his own non-organic diagnosis and is constantly on the alert for evidence of organic pathology. No effort will be made in this paper to elucidate the diagnosis of functional psychosis. The purpose is rather to define those symptoms which are suggestive or diagnostic of organic disease, especially as they are found in the patient who is first thought to have an emotional disturbance. It concerns the problem of whether a person who clearly has a functional illness also has organic disease and whether a given patient has an organic or functional disorder. It deals only with psychosis.

Characteristics of the Organic Syndrome

The organic brain syndrome, as classically described, consists of confusion, impairment of orientation, memory, apperception, knowledge, and judgment; and instability and shallowness of affect¹. Any one of these symptoms may occur in psychological illness also. The clinical picture which includes all of these is clearly indicative of organic brain disease. We will discuss additional characteristics which in our experience are helpful in suspecting or diagnosing organic disease.

Delirium

Delirium is found only in organic disease. It

The patient with organic brain syndrome does not challenge the feelings of the doctor or evoke any strong emotional response in the physician.

occurs as the result of a physiological disturbance in cerebral metabolism, and therefore is always organic in origin. Romano² describes the "slow motion" development of delirium step by step. The first symptom is a *decrease in awareness* and this may be so slight as to be detectable by only a sensitive test such as subtracting serially seven from 100. The next symptom is *irritability* followed by *sleeplessness, apprehension, anorexia, loss of orientation*. Orientation is lost first to time, then to place, then person, i.e., in reverse order from the natural development or orientation in the growth of the infant and child; after this occur *delusions, hallucinations, and excitement*. The patient with psychological illness can, of course, develop delirium, but only because of a disturbance in cerebral metabolism. Common causes of delirium are fever, drugs, malnutrition, dehydration, pain, exhaustion, infection and anoxia. Delusions which occur in delirium may be indistinguishable from delusions which occur in psychological illness. For example, a patient is reported to have refused food and water for fear it was poisoned, and thought that people were after him with guns in order to kill him. These delusions were of organic origin and disappeared upon evacuation of a subdural hematoma. The patient was also confused, disoriented, excited, and irrational^{3,4}. Hallucinations as they occur in the delirious patient are different from those in the schizophrenic and thus offer an important differential diagnostically.

The hallucinations of the delirious patient are "homely" in that they invoke seeing members of the family who are not actually present, and confusing people around them with family and acquaintances. An exception to this occurs in the patient with delirium tremens but the hallucinations in this disease are usually so specific in character as to present no real problems. The schizophrenic patient has hallucinations of a different character and these are usually bizarre, foreign, and exotic.

Another helpful diagnostic point may occur when the organic patient recognizes his hallucinations as being hallucinations, even though he continues to have them.

Physical Findings (Other Than Delirium)

Every patient who elicits a diagnosis of psychiatric illness should have a complete physical examination including a careful neurological evaluation. This is absolutely essential for patients who have any of the symptoms which can possibly be of organic origin. Such admonitions are perhaps well known to all of us and yet situations do arise in which they are overlooked. This happens sometimes in the case where a physician feels sure from a brief history that the patient is suffering from a psychological illness and should be referred for psychotherapy. Physical examination is omitted because it seems almost superfluous, and the stage is set for the possibility that a patient with organic psychosis will be treated improperly. The physical examination should particularly include a search for evidence of delirium, focal neurological signs, and any evidence of "sickness." The height of suspicion should go up if the patient *looks* sick, even if no other physical findings are present.

Discrepancy Between Previous Personality and the Presenting Picture

The psychiatric history may be of great value in distinguishing organic from psychological illness and especially when it points up the probability of organic psychosis. This is especially true when it is discovered in the history that the patient has had a "personality change". In taking a psychiatric history, one has in mind a continuum from the pre-morbid personality to the disease state. Psychiatric symptoms follow patterns which are familiar to the alities under the impact of certain stresses. The symptoms follow patterns which are familiar to the psychiatrist. Deviation from the expected pattern should arouse suspicion of organic psychosis. In one case, not included among the case reports, the discrepancy between the psychiatric history and the presenting symptoms was the deciding factor in favor of performing a craniotomy, which revealed

that the illness was organic in origin. Thus the psychiatric examination may rule out, or make doubtful, a psychiatric diagnosis. It should be mentioned, however, that pre-existing neurotic symptoms may increase in severity in the face of organic central nervous system disease. In this case, the discrepancy discussed above does not exist. Other evidence of organic disease is usually present.

Difficulty in History Taking

Taking a history may be difficult in various situations. However, there appears to be some specificity encountered with the organic patient. For one thing, the patient with organic disease is usually cooperative in contrast to a psychotic patient who has been forced to see the physician by his family, legal agencies, or any other source which may seem punitive to the patient. The organic patient is likely to be somewhat frightened by his symptoms, reluctant to share them with family or physician, and have difficulties in communication because of his tendency to confabulation, perseveration, confusion, and circumlocuousness. His difficulties seem to be entirely within himself. These difficulties do not ordinarily cause the physician to feel that the patient is deliberately making things difficult for the doctor. In contrast, the difficulty in taking a history from a severely ill schizophrenic patient is more interpersonal and is more likely to arouse feelings of hostility on the part of the examining physician.

Lack of Concern

Lack of concern has been very helpful to us in suspecting organic rather than psychological illness. The patient reports without anxiety, symptoms which would ordinarily be very disturbing. This is apparent even though the patient may be hyper-emotional with crying spells and inappropriate outbursts. He may cry in the interview then suddenly continue calmly. The patient in the third case reported below described a loss of sexual potency and had no anxiety about it. Instead of being concerned about his memory loss he made some effort without anxiety to fill it in with confabulation. When he stared into space the people around him did not feel tense nor did they feel that he was tense. By contrast, the immobile catatonic patient gives the impression that he has a great deal on his mind and is enormously involved with his own feelings. Because of these intense feelings, the examining physician is usually uneasy. Patients with organic brain disease give the impression that they do not take their symptoms personally. The lack of concern is similar to what might be expected if they were telling about something which had happened to somebody else and for which they had little or no responsibility. When

ORGANIC PSYCHOSIS / Felder

the organic patient is dangerous, it is without intending to be so. It is difficult to describe the difference between this organic lack of concern and the apathy of the schizophrenic patient. However, these two phenomena do affect the examiner differently.

Lack of Rapport

The relationship which develops between the organic patient and the doctor differs from that which the physician has with the functional psychotic patient. The organic patient stimulates feelings of sympathy, pity, and the desire to help just as do patients with other physical illness. The organic patient does not challenge the feelings of the doctor or evoke any strong emotional response in the physician. The schizophrenic patient, on the other hand, even though communication is extremely difficult, somehow challenges the physician and stirs him up emotionally. An example of this is found in case No. 2. When the doctor remarked that the patient was crazy, the patient accepted this quite nonchalantly; neither the patient or doctor were embarrassed. The same patient had in his confusion tried to shave himself with a toothbrush. The patient did not present this to the doctor as a problem. It seemed of little consequence, nor was it disturbing to the doctor in the sense of being embarrassing. In case No. 3, the patient's suicidal feelings were presented similarly. The relationship of patient to doctor was such that this problem was not presented as something which the doctor was to do something about, but rather as a phenomenon which seemed unreal. That is, it seemed ridiculous rather than dangerous. Actually it was dangerous. The lack of rapport accounts for the doctor's failure to feel it as such. This lack of rapport is found not only in the relationship of the patient to the physician but also in his relationship to his family. He does not tell his family about his peculiar thoughts and feelings and he makes no effort to get help from them with these phenomena nor to saddle the family with any responsibility for them. By the same token, the relationship of the family to the patient is typical with the functional patient. The family of the functional patient develops much feeling about the patient and his illness, this nearly always includes considerable hostility either overt or covert. Such hostility is noticeably absent in the family of the organic psychotic patient. The family is warmly solicitous as though he were sick with other physical illnesses.

Case Reports

Case No. 1: The patient was referred with a psy-

chiatric diagnosis. The referring physician sincerely did not feel that he needed to subject the patient to a complete physical examination. She was a 40 year old woman who had been a chronic complainer and had made innumerable visits to many physicians. She had begun to have some sort of spells and when her husband reported to the physician that she had gotten up in the middle of the night to fix lunch the referral to a psychiatric hospital was made. During the psychiatric history taking, it evolved that she had had headaches for ten years, mostly frontal. Those were always worse with her menstrual periods and were frequently associated with nausea and vomiting. About two months prior to admission, however, these headaches had become more frequent, more severe, and associated with episodes in which she felt she was blind for short periods of time. Also during the two months before admission she had developed polyphagia, polydipsia, and polyuria. Frequency of urination was about every 30 minutes and on one occasion she had gotten up 20 times during the night to drink water and to urinate. She had had generalized muscular aching for six weeks before admission, generalized hyperesthesia of the skin, and some episodes of jerking of all extremities followed by 15 to 20 minutes of extreme fatigue. There was no history of tongue biting or definite convulsion. Three weeks before admission, she had apparently developed a generalized anascara which was treated by one of her physicians and responded to the therapy. For some ten days, she had had hallucinations, disorientation, and finally had become irrational and was refusing water or food. There was no family history of diabetes. She had had amenorrhea for about two months. There was a past history of mild asthma over a period of about four years.

Presumptive Diagnosis

Temperature was 100°, pulse 120, respiration 22, blood pressure 80 to 100 systolic, and 60 diastolic bilaterally. The patient was disoriented, sometimes unmanageable, quite dehydrated, and appeared ill. Extraocular movements were normal and no nystagmus was present. The left pupil was slightly larger than the right and both reacted to light. There was early papilledema with venous distention on the left and questionably also on the right. No hemorrhages or exudates were present. Sensory examination was not possible because of the patient's delirium. Deep tendon reflexes were all present, equal and normal. Babinski was equivocal. A presumptive diagnosis was made of organic psychosis with some kind of hypothalamic tumor, and the patient was transferred to a general hospital. There the presence

of a hypothalamic tumor was confirmed and it was found to be metastatic from a bronchiogenic carcinoma.

Discussion

Specific consideration led to the mistaken diagnosis with this patient. For one thing, she had been known to be neurotic for many years. She was a very dependent person who had lost 30 pounds of weight when her husband had gone to the Army and gained it back when he returned. Two weeks prior to her referral to the hospital, a close neighbor had committed suicide and this had been very upsetting to the patient. Shortly before that, her son had had a rather severe altercation with his father which had been further upsetting to the patient. Also in the recent past, her daughter and son-in-law had developed a serious marital problem. The referring doctor had every reason to assume a psychiatric diagnosis. In the psychiatrist's history taking, the delirium, lack of concern, difficulty in history taking and lack of rapport made him question the functional diagnosis. He then took a more exacting detailed medical history revealing symptoms which, if the referring doctor had been acquainted with, he too would have made an organic diagnosis.

Case No. 2: This is a 51 year old man who was referred to a psychiatrist as an emergency with the message that it was feared he might become dangerous. He had always been very sensitive to stress and when he became worse, his physician assumed a functional psychosis. Further information with the referral stated that he stared into space, couldn't make decisions, had stopped work, had collapsed two weeks previously and had complained of dreadful headaches. During the psychiatric history taking, the following information was elicited: he had had headaches for the entire 26 years of his married life, sometimes with vomiting; for the past year he had been emotionally unstable, had appeared pale, cried easily and worried a great deal about his job. He had also been hypersensitive to any stress. Four months previously he had had an attack of nervousness which lasted one to two weeks with associated headaches and vomiting. For two months he had had difficulty with his memory. One month previously he had had a period of blankness in which he was staring into space. Two weeks before the examination, he had developed aphasia, dysarthria, incontinence, and bizarre behavior including an attempt to shave his face with a toothbrush. Several observations during the course of the history taking were further confirmatory of organic disease. The patient staggered as he entered the office, had no evidence of anxiety, was disoriented, did not know

the name of his own child, had no reaction when told that he was crazy, was quite confused, and attempted to fabricate. There was no feeling of hostility in the family toward the patient and his illness. He was referred to a neurosurgeon who discovered a space-occupying intracranial lesion.

Discussion

In summary, this again is the kind of patient a physician would assume to be a functional psychotic. He had always been very sensitive to stress. A more detailed examination revealed symptoms of confusion, disorientation and memory defect. He was now insensitive to stress. These symptoms would lead the physician to suspect an organic basis. These suspicions were further increased by the lack of anxiety in the patient, lack of hostility in the family, and the peculiar lack of rapport with the physician. Also there was a discrepancy between the patient's previous personality and his present illness. These prompted referral to a neurosurgeon.

Case No. 3: In this case, the evidence of organic disease as it was found in the psychiatric history taking is even less evident. This was a 40 year old man with a life history of socially acceptable behavior. He rather abruptly began to have angry outbursts, which got him into difficulties with his church, his club, and his relatives. He was arrested for one such incident, and this occasioned his referral. He had lost interest in everything, had no desire to live, had thoughts of killing himself, was very depressed, and had had homicidal impulses. The patient was clearly paranoid, but the paranoia took the form of a generalized feeling which was not systematized. He simply felt frightened. He was very reluctant to share his thoughts with either the family or the doctor. His homicidal feelings were impetuous and were described as "just a feeling" rather than plans. His suicidal feelings seemed unreal to him. He felt like he would hurt himself, but considered this feeling to be ridiculous. Other symptoms included crying spells, weight loss, apathy, mutism, headaches, irritability, loss of sexual potency, and memory loss for recent events. None of these symptoms made him anxious. The history was very difficult to obtain. An organic basis was suspected and the patient was referred to a neurosurgeon who discovered bloody spinal fluid.

Discussion

The classic syndrome of organic psychosis was absent here, except for the distinct memory loss. However, certain phenomena justified further physical examination. The patient was not anxious. History taking was difficult. There was poor rapport

between doctor and patient. A discrepancy was discovered between the patient's present personality and his previous psychological make-up. Finally the illness did not fit into familiar psychiatric patterns.

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ANNUAL EXAMINATION HELD AT GRADY HOSPITAL

THE ANNUAL EXAMINATION FOR the United States given by the Sub-specialty Board in Cardiovascular Disease was held at Grady Memorial Hospital, December 11 and 12. The following members of the faculty of the Emory University School of Medicine participated: Dr. Heinz Bauer, Dr. James Rogers, Dr. Osler Abbott, Dr. Gerhardt Brecher, Dr. Robert Schlant, Dr. Willis Hurst, Dr. Gordon Barrow, Dr. Sterling Claiborne, Dr. Carter Smith, and Dr. Bernard Lipman. Guest examiners from

other cities were: Dr. Harry Harper, Augusta and Dr. Dr. Edward Orgain, Duke University. Members of the Sub-specialty Board are: Dr. Charles A. R. Connor, New York; Dr. A. Carlton Ernstene, Cleveland, Ohio; Dr. Frank B. Kelly, Chicago, Ill.; Dr. Murray Kinsman, Louisville, Kentucky; Dr. Raymond D. Pruitt, Houston, Texas; Dr. Calvin Kay, Philadelphia, Pa., and Dr. Bruce Logue, Atlanta, Chairman.

PUBLIC HEALTH DEPARTMENT REORGANIZATION

A REORGANIZATION OF THE Georgia Department of Public Health into three major divisions of mental health, physical health, and administration and finance became effective January 4 when the Department began the new year with a new director, Dr. John H. Venable.

Dr. Venable, whose appointment became effective on New Year's Day, succeeds Dr. Thomas F. Sellers, who remains as director-emeritus after 12 years as director and 42 years with the Department.

Creation of the Division of Mental Health had been previously announced as part of the Department's plans for giving new emphasis to mental health in its organizational structure. Within this division are Community Mental Health Service, directed by Dr. Trawick Stubbs, and the Milledgeville State Hospital, with Dr. Irville H. MacKinnon as superintendent. Community Mental Health Service continues the activities of the former Division of Mental Health in promotion of intensive treatment centers, child guidance clinics, and training of public health nurses to assist mental patients and their families at home. A director for the new Division is being recruited.

The Division of Physical Health, directed by Dr. S. C. Rutland, includes branches of public health activi-

ties of the Department. These are dental health, environmental health, laboratories, health conservation, preventable diseases, organization of local health services, operation of Battey State Hospital, and services to hospitals in the state.

The Division of Administration and Finance, directed by Ernest B. Davis, includes accounting, statistics, health education and training, personnel, and vital records.

Dr. Rutland will also serve as deputy director of the Department, with Mr. Davis serving as assistant to the director.

Dr. Venable also announced the names of members of a Departmental Advisory Council. These are Dr. Sellers, director emeritus; Dr. Rutland; Mr. Davis; Dr. Lester M. Petrie, deputy civil defense director and director of preventable diseases branch; Roy J. Boston, director of environmental health; Dr. John E. Chrietberg, director of dental public health; James M. Sitton, director of hospital services; Miss Theodora Floyd, director of public health nursing; Dr. W. J. Murphy, director of epidemiology; Dr. Guy V. Rice, director of health conservation; and Dr. E. J. Sunkes, director of laboratories. The director of the Division of Mental Health, when recruited, will also serve.

DELAYED TRAUMATIC RUPTURE OF THE DIAPHRAGM

Robert H. Vaughan, M.D. and Robert Hardaway, Col., M.C., U.S.A., *Columbus*

This entity actually represents an evisceration of the abdominal contents into the chest cavity.

TRAUMATIC RUPTURE OF THE DIAPHRAGM is a surgical emergency. For the most part this defect should be corrected as early after trauma as possible. The injury which causes this may be direct, indirect or as a result of inflammatory necrosis. The first type was most often seen during the war crises and resulted from shrapnel, bullet and/or knife wounds. The ever present possibility of bowel injury and the concomitant deranged cardio-respiratory physiology make early surgical exploration imperative. The second category of traumatic "evisceration of the abdominal viscera into the chest" is seen as the result of a crushing blow to either chest, and there is no wound of entry seen. This may be referred to as the indirect type and it usually occurs through a small rent in the diaphragm. There may be associated injury to the spleen and kidney with the added possibility of a ruptured viscus¹. Certainly these possibilities should be considered at the time of injury. There are often associated fractures of the ribs, spine, and pelvis. The third type is perhaps the rarest of all and is associated with a sub-diaphragmatic abscess or with erosion of the diaphragmatic surface as a result of drainage tubes. Also with the recent increase in division of the diaphragm in thoraco-abdominal incisions, separation of the suture line and dehiscence has to be considered.

As has been pointed out by Harrington² and Churchill³ this entity of traumatic rupture of the diaphragm is actually an evisceration of the abdominal contents into the chest cavity. There is no sac. And as Carter⁴ has emphasized, if there is a portion of the stomach present in the chest, the abdomen may well be scaphoid with several loops of bowel

among the viscera present in the hemithorax. These latter may or may not be incarcerated or strangulated. The patient in this predicament will not be able to vomit. One cannot vomit from a stomach displaced into the chest; one retches. (To vomit, the diaphragm is set, and the abdominal muscles are contracted.)⁵ Herniation of abdominal viscera into the thoracic cavity may occur at the time of injury and not become apparent for many months. Straining, vomiting or some similar effort may accentuate the hernia and cause symptoms and signs of obstruction.

Case No. 1

H.M. was a 34 year old white man who was admitted to the CCH on the afternoon of 5/24/54 after he had been crushed under some falling logs 30 minutes before. While unloading a logging truck, one of the chains slipped and allowed the entire load to fall across him. The bulk of the crushing force was on this left side, including his chest, abdomen, and pelvis. He complained of pain in his left chest, left abdomen, and across his lower back; appeared ashy in color, and felt cold and clammy. His B.P. was 98/60 and his pulse 160, and respirations were 26 per minute. There were some abrasions and contusions over the left chest and left flank and breath sounds were diminished in the left chest. His abdomen was soft and peristaltic sounds were audible. There appeared to be a haziness (traumatic pneumonitis) in both lung fields and roentgenograms revealed multiple fractures of all the ribs of the left chest and fractures of both pelvises. The left diaphragm was not clearly seen and what appeared to be an air bubble was present above this. There was no shift in the mediastinum and the patient appeared to be in no respiratory distress. There was a pneumothorax, and because of

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this a closed thoracotomy was performed on the left. His laboratory studies were within normal limits.

I first saw the patient the day after his admission and because of the absence of bowel loops in his left hemithorax, despite the fact that I could not see the diaphragm well, and the fact that the patient's condition appeared to be good I counseled against operation at this time. Instead a Levine tube was placed in his stomach and a complete intercostal nerve block performed. The patient developed an ileus which was not relieved by the use of the Levine tube, and enemas were also of little avail in the beginning. However, on his third day post trauma he did pass flatus and his condition appeared to improve. The next day he was placed in Russell's traction. Shortly after this he became dyspneic and because of labored respiration and difficulty in raising his sputum a tracheostomy was performed. His condition continued critical and he complained of a "pushing sensation" in his chest. On 5/29/54 he passed a large liquid stool and much flatus. His abdomen became more scaphoid. On 5/30/54 he had an episode of hemoptysis and would have expired had he not been aspirated by a vigilant intern. On 5/31/54 films revealed a shift of his mediastinum to the right and his abdomen was scaphoid and peristalsis audible. On 6/1/54 his breathing was labored and rapid and a portable film revealed a shift of the mediastinum more marked to the right with what appeared to be, for the first time, dilated loops of bowel in the left chest. He was taken to the operating room and through a left parascapular incision the seventh interspace was entered and several loops of collapsed small bowel, a portion of the stomach containing the Levine tube, and a loop of dilated transverse colon were found. A two inch rent was found in the anteromedial aspect of his left diaphragm lateral to the esophageal hiatus. All of the viscera with the exception of the transverse colon which, was markedly distended, could be easily reduced, but a 15 gauge needle attached to the suction was placed in the transverse colon and this had to be decompressed before the latter could be replaced in the abdomen. The rent in the diaphragm was closed with No. 1 silk sutures. The patient's blood pressure had been maintained with blood and levophed and his chest was quickly closed at the completion of the hernia reduction. After a difficult post operative course during the first two or three days, he improved and made an eventual uneventful recovery. He was discharged from the hospital on 7/26/54 on his 62nd hospital day. I have subsequently seen

this patient within the past two years and he is again working as a logger and truck driver.

Case No. 2

D.K., a 40-year old white man was admitted to St. Francis Hospital on June 26, 1958 with the chief complaint of colicky abdominal pain so severe that he required large amounts of opiates, that only afforded partial relief. His abdomen was distended and there was evidence of high pitched peristaltic sounds. The abdominal three position films were consistent with mechanical intestinal obstruction.

Three years prior to this present admission he sustained a crushed left chest and injuries to both arms in an automobile accident. I saw the patient at this time and because of a left pneumothorax did a closed thoracotomy. The patient eventually made a recovery from his accident but in the interim had episodes of substernal discomfort. He was diagnosed as having "heart disease" and/or malingering. The laboratory studies were unremarkable. Because of the suspected possibility of a concomitant chest lesion, on the way to the operating room where an intended exploration of his abdomen was planned, chest films were taken. There proved to be a definite air fluid level in the left chest which on the lateral films appeared to be continuous with the colon in the anterior aspect of the abdomen. Accordingly it was thought wiser to open the left chest through the eighth interspace.

There was a definite mass of omentum caught into a relatively small rent in the anteo-lateral aspect of the diaphragm (estimated 1½ inches) and in addition there was a large portion of the transverse colon present in the left chest. The colon as well as the omentum was adherent to the wall of the defect and also to the superior aspect of the diaphragm. It was necessary to ligate several large vessels of the omentum in order to remove a portion of this to make it possible to reduce the herniated viscera. Certainly with the amount of colon present in the chest it was entirely possible that the patient had had intermittent obstruction from this in the past. Once the herniated bowel had been reduced the edges of the defect were excised and closed using silk sutures. This was closed in two layers. The patient tolerated this procedure well and left the operating room in satisfactory condition. He made an uneventful convalescence from his surgery and was discharged from the hospital on 7/3/58. I have seen the patient in the last month and he continues well.

Case No. 3

A 25 year old white male soldier was admitted to the Medical Service of the 97th General Hospital,

Frankfort, Germany, with a chief complaint of nausea and vomiting following an alcoholic debauch over a period of two previous days. Soon after admission, he became restless, dyspneic, and cyanotic. Roentgenogram of the chest revealed what appeared to be gas in bowel in the left chest. It was thought that a diaphragmatic hernia might be present but no cause for it could be found. He was transferred to the Surgical Service. Close physical examination revealed a 1 cm. linear scar on the lateral aspect of the lower left chest. Upon being questioned about this scar, the patient for the first time, gave a history of being stabbed in a knife fight in Korea two years previously. At that time, he had no hospital treatment. He had suffered no ill effects from the wound and it healed spontaneously without medical aid. Thoracotomy was performed and the entire splenic flexure of colon, together with most of the great omentum, was found protruding through a 2 cm. hole in the dome of the left diaphragm. There was moderate strangulation with discoloration of the bowel. It was necessary to extend the defect into the diaphragm in order to reduce the herniation. After reduction, the diaphragmatic defect was easily repaired with interrupted cotton. The patient made an uneventful recovery. It was thought that at the time of the original knife wound, a small slit was made in the diaphragm which was plugged with omentum. At the time of the severe vomiting two years later, omentum and colon were forced through the hole.

Summary

1. Traumatic rupture of the diaphragm represents an evisceration of abdominal contents into the chest. There is no associated sac.

2. The most common cause is indirect trauma (as in a fall or automobile accident) where the crushing force makes a rent in the diaphragm. This occurs in the left side predominantly; however, it may occur on the right as well.

3. Once recognized the patient should be operated upon as soon as he is considered an adequate candidate for surgery. If a portion of stomach is in the chest the abdomen may well be scaphoid with a strangulated loop of usually large bowel present in the chest space.

4. One must think of the possibility of a ruptured diaphragm when there has been a crushing injury either from direct or indirect trauma. This may well lead to an early successful operation and with the saving of a life as well as much discomfort to the patient.

5. Occasionally with blunt trauma and associated rupture of the thoracic diaphragm, herniation of the abdominal viscera into the thoracic cavity occurs and is not detected for many months, while in some instances immediate symptoms appear and the condition is promptly recognized.

Physicians Building

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SECTION OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

AT THE MEETING OF the Southern Medical Association in Atlanta, Georgia on November 15-19, 1959, the following officers were elected for the Section of Ophthalmology and Otolaryngology for the coming year:

Chairman, Dr. George M. Haik, Professor and Head of the Department of Ophthalmology at Louisiana State University School of Medicine, 812 Maison Blanch Building, New Orleans 16, Louisiana.

Chairman-elect, Dr. Mercer G. Lynch, Assistant Professor of Otolaryngology, Tulane University School of Medicine, 3503 Prytania Street, New Orleans 15, Louisiana.

Vice-Chairman, Dr. Bernard J. McMahon, Director

of the Department and Clinical Professor of Otolaryngology, St. Louis University School of Medicine, 8230 Forsythe Blvd., Clayton 24, Mo.

Secretary, Dr. Albert C. Esposito, First Huntington National Bank Building, Huntington, West Virginia. Formerly instructor of Ophthalmology, Ohio State University College of Medicine, Columbus, Ohio.

The next meeting of the Section will be held in St. Louis, Missouri from October 31 to November 3, 1960. Those interested in participating should write to the Secretary of the Section, Dr. Albert C. Esposito.

CLINICAL ASPECTS OF WATER AND ELECTROLYTE METABOLISM IN THE NEPHROTIC SYNDROME

Staff of the Medical College of Georgia, *Augusta*

DR. THOMAS FINDLEY: The conference today is a very special occasion because the case will be discussed by the Directors of the two Georgia Heart Association Laboratories for Cardiovascular Research. Dr. Elbert H. Tuttle of Emory has very kindly consented to join us and I think we may expect some debate between him and Dr. J. Edwin Wood, III who has recently come from the Massachusetts Memorial Hospital in Boston to join our faculty in a comparable position. When the conference is over I think you will conclude that the money contributed to the Georgia Heart Association has been wisely invested.

Dr. Fred Jones, Intern in Medicine, will present the patient.

DR. FRED JONES: The patient for discussion today is a 53 year old white female who was admitted on the 22nd of November with a referring diagnosis of the nephrotic syndrome. Pertinent history is that some six years before admission she was stung by a wasp, apparently without ill effects at the time, and shortly thereafter she noticed dysuria, weakness, easy fatigueability, dyspnea on exertion, two-pillow orthopnea, and for the first time dependent edema. The edema progressed and became generalized after a week. She was admitted to her local hospital ten days prior to admission here, and was found to have massive proteinuria, low serum albumin, a serum cholesterol of 536 mg. per cent, and a normal serum NPN. An intravenous pyelogram was considered to be normal. She was treated with prednisone for a short time, and apparently had a good diuresis. Following dismissal from her local hospital she began to reaccumulate edema. Prednisone therapy was re-

instituted, and she apparently had diuresed to some extent by the time she was seen here.

On admission she was afebrile, had a pulse rate of 80 per minute and a blood pressure of 150/80 mm. Hg. There was facial puffiness as well as minimal edema of the pretibial and presacral areas. Other physical findings included a scar of the left pinna and a dull left tympanic membrane without perforation (history of chronic otitis for some eight years). Examination of the chest and lungs was not unusual. There was no apparent cardiac enlargement, the cardiac rhythm was regular and no murmurs were heard. No abdominal organs or masses were palpable and rectal and pelvic examinations were not abnormal. Her weight was 70 kilograms, some four kilograms above her usual level.

We will discuss the laboratory values again (Figure 1), so I will mention them only briefly at this time. Her corrected sedimentation rate was 48 mm. per hour, the hematocrit 43 per cent, the white blood count 6,400 per cu. ml. The BUN was 18 mg. per cent, the cholesterol 610 mg. per cent, and the serum protein 3.6 gm. per cent, with an albumin of 1.5 gm. and a globulin of 2.1 gm. per cent, thus a reversal of the A-G ratio. Urinary protein was two grams per 24 hours.

It was felt that she warranted another trial on steroids. First, however, we attempted to reduce the edema with an oral diuretic. She was begun on hydrochlorothiazide, 50 mg. twice daily. Initially she experienced some diuresis associated with weakness and a fall in blood pressure, but after a few days it was apparent that she was not going to diurese satisfactorily, and on December 6th she was begun on prednisone. However, this induced no diuresis; as a matter of fact, her weight increased. Hydrochloro-

Transcription of a regularly scheduled weekly conference of the Department of Medicine, Medical College of Georgia, Augusta, Georgia, January 29, 1959.

thiazide was discontinued but prednisone was continued in the dose of 60 mg. daily.

She was allowed a leave of absence from the hospital for the Christmas holidays and returned early in January. Her course at home had been uneventful except for a flare up of otitis media, for which she was treated with penicillin by her physician. She did experience weakness and anorexia while at home. On readmission she seemed to be in quite good condition. She had minimal edema and her weight was 71 kilograms, which was just slightly more than that of her initial admission but not as high as it had been before the Christmas holiday. In the next several days, however, she rapidly accumulated edema fluid, ascites became evident, and she became dyspneic. During this time she was continued on prednisone. Hydrochlorothiazide was given with temporary improvement, but then her weight went up to even higher levels and she was noted to have an increase in BUN. Another thing that concerned us was the elevation of her serum potassium up to 7.6 meq/l. with EKG changes compatible with hyperkalemia. During this time she continued to have rather marked proteinuria, in fact this had increased in amount. We were looking for something else to do for her, and Dr. Findley suggested that Dextran® might help. We gave her 500 c.c. of Dextran® intravenously slowly. During the initial 12 hours following its administration, there was a marked diuresis. She put out 4,700 c.c. of urine in the first 24 hour period following the Dextran®. During this same time, because of the definite increase in venous pressure and the onset of orthopnea, she was digitalized over a three-day period. At the same time prednisone was discontinued.

The following day she had a sudden onset of left anterior chest pain without associated fever (of course, we have to remember she had been on steroids), but with a white blood count of 31,000 per cu. ml. and 83 per cent segmented forms. We saw pneumococci in the sputum and placed her on penicillin. She remained afebrile for two days, then began to spike a high fever. The sputum culture grew staphylococcus, coagulase positive, sensitive to erythromycin which was added to the therapy. With this infection she showed marked improvement in every respect. The edema diminished considerably, and the proteinuria reached its lowest level during hospitalization. The serum albumin went to its highest level of 3 gm. per cent and the BUN became normal. Her serum potassium was 3.8 meq/l. and generally she felt much improved, even while she was febrile and had a leukocytosis.

The pneumonia has now cleared and her white blood count is 6,800 per cu. ml. However, her

weight has started to climb again and she has lost approximately 20 grams of protein in her urine in the last 24 hour period. All evidence indicates that she is returning to her previous situation with a high potassium, an elevated BUN, diminished urinary sodium excretion, and edema. That is her status just now. She is on no steroids and no diuretics. Her weight this morning was 1 kilogram greater than it was yesterday.

DR. J. EDWIN WOOD, III: This patient presents a classical case of nephrosis; i.e., a low serum albumin, large quantities of albumin in the urine, high serum lipids, and a great deal of edema. In addition, the syndrome may have started as a result of an allergic stimulus, namely a wasp sting. We would like to examine this patient's hospital course and attempt to explain some of the things that have happened to her in terms of the pathophysiology of the nephrotic syndrome. First, let's have a word with the patient. How are you feeling this morning?

PATIENT: Better than before, Doctor.

DR. WOOD: How about the swelling of your legs, do you think that's improved recently? Has it changed any in the last day or so?

PATIENT: It is somewhat worse.

DR. WOOD: How about your breathing?

PATIENT: That is much better than it was a few days ago.

DR. ELBERT H. TUTTLE: About a week after you came in did you have a lot of trouble with your breathing? Did you lie flat in the bed or did you want to sit up?

PATIENT: I had to sit up to get my breath.

DR. WOOD: Dr. Tuttle had a chance to see the patient earlier. As a starting point, Dr. Tuttle, can we begin by discussing the therapy in this patient, and her lack of response to therapy. The chemical findings which I would like for you to go over are extremely complex, particularly with reference to the edema formation, the azotemia, and the apparent onset of congestive heart failure.

DR. TUTTLE: I wonder if I could take about five or six minutes to outline what I think is the pathological physiology of the problem in general, and then talk about the therapy and how it modifies the disturbance of physiology as we see it. We have thought that the nephrotic syndrome or the edema that develops in nephrosis is a compensation of the body for a reduction of the effective circulating blood volume as is seen in many states of edema with water and salt retention. We visualize the pathogenesis of the edema in nephrosis as being due to the loss of serum albumin, a reduction of the osmotically active proteins within the vascular compartment, and as a consequence of that, a tendency

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of the blood volume to fall. This triggers off a set of reflexes that lead to a retention of water and salt by the body in an effort, so to speak, to replace this blood volume that has leaked out of the vascular compartment because of the low oncotic pressure. If the body is effective in obtaining adequate amounts of salt and water and in holding on to them, by building up the volume of the extracellular compartment, it can actually restore the volume in the vascular compartment, even without the help of the oncotically active albumin that's been lost. There is a feedback mechanism by which salt and water are accumulated as the albumin is lost, and the net change in blood volume is not very great. But if the body did not retain the water and salt there would then be a significant reduction of the actual plasma volume and a deficiency of the circulation.

The problem then becomes one of what mechanisms produce the retention of water and salt. This argument goes on in congestive heart failure, it goes on in cirrhosis of the liver, it goes on with nutritional edema, and it goes on in the nephrotic syndrome. There are many points in the total physiological complex where you can postulate that the difficulty begins. For instance, since this is a renal disease, it has been thought that perhaps the reduction of the glomerular filtration and the filtered load of sodium might account for the retention of water and salt, but we recognize the fact that in the nephrotic syndrome, frequently in children and sometimes in adults as well, the glomerular filtration rate is above normal. In spite of this fact these patients may have massive anasarca. Thus it seems unlikely that the basic pathogenesis of the retention of water and salt is a reduction in glomerular filtration. In addition to this, it has been determined by the rather difficult bioassay procedures and the as difficult biochemical procedures that there are increased amounts of aldosterone present in the urine in the nephrotic syndrome. The significance of this is hard to be definite about because the amount of aldosterone that comes out in the urine is a small fraction of that which is actually secreted, and we are making a big jump when we infer how much aldosterone is circulating from how much appears in the urine, but at least this is a suggestion that there may be an adrenal cortical factor in the retention of water and salt. If we eliminated the reduced glomerular filtration of sodium as a factor, then the tubular reabsorption must then be playing some role.

As the best working hypothesis with which to view these patients, we have thought that the mechanism of edema formation was a stimulation of some volume-sensitive receptor in the vascular tree,

which responds, not to the absolute total blood volume, but to some function of blood volume which is related to or complicated by the competency of the heart to put out blood and by the actual size of the vascular compartment. In other words, we postulate a "volume receptor" which is sensitive to a relationship between the volume of the blood, the size of the compartment in which it is contained, and the actual capacity of the heart to pump. There is some site in the body which, other things remaining equal, will respond to a reduction of actual blood volume with a reflex mechanism which increases the tubular reabsorption of sodium. This is probably mediated through the aldosterone-secreting mechanism of the adrenal gland and through the tubular reabsorption of sodium. So we think that the basic problem in nephrosis is the loss of albumin. You can't correct the physiological deficiency entirely unless you can correct the loss of albumin from the body; but in trying to visualize how to give symptomatic relief for the edema you have to play upon the tubular reabsorptive mechanism and at the same time if you can increase the amount of salt which is filtered that will potentiate any sort of effective therapy you can direct at the renal tubule.

We would like to remove the lesion that we think occurs in the basement membrane of the glomerulus that causes the leakage of albumin. Though the pathogenesis of that lesion is not clear, since it is thought to be allergic, the concept of the use of adrenal cortical steroids has come up. Empirically this does have a beneficial effect. The 24-hour albumin loss will diminish and a patient with nephrosis may become actually free of albuminuria under treatment with steroids. If you accomplish this, then you correct the basic lesion that is causing all of the other things to follow in its train. Unfortunately the steroids are not universally effective, nor are they permanently effective in many cases, so that we have only a partial response in many patients. We may have a complete response at one time and then a recurrence at a later date. Since we don't know the mechanism by which the steroids affect the loss of albumin, we don't really know why some respond and some don't. We end up with an empirical regimen and we don't have any good directives except trial and error as to what sort of dose schedule we should follow. In the original cases, ACTH and cortisone were used in relatively small doses. As time went on it became evident that the percentage of cures was small and the relapse rate was high. The dosage administered has since been increased to quite high levels. The current feeling in most of the places where large numbers of nephrotics are being treated is that we should really use high

dosages; it depends upon what drugs you're using as to what this actually amounts to in milligrams, but this patient got up to about 100 mgm. of prednisone, which is equal to 400 or 500 mgm. daily of hydrocortisone or a quite large amount of ACTH. A dose like this may produce a remission, but the relapse rate has been so high or the failure to clear completely has been so bothersome that many people have recommended really long term therapy even after the edema has disappeared.

When the rate of albumin loss has fallen off so that people are able to maintain an adequate circulation without edema, the presence of albumin in the urine is evidence that the pathological lesion is still present. For that reason many people are establishing a maintenance dose of steroids for these patients until they are free of albuminuria and have been so for quite a long period of time. In an effort to minimize the complications of the Cushing-like picture that develops on these high doses of steroids, intermittent dose schedules have been developed, and now in some clinics it's customary to give the steroids in high doses for three days out of the week and leave them off for the other four. Some other clinics are giving doses on every other or every third day. It does seem that the number of remissions is higher with the larger and more prolonged dosages given in the initial treatment, and that the persistence of the remission seems to be better if maintenance steroids are being used, but I can't give you any concrete hard and fast rule of therapy because the control data is not very good. Each patient has been treated a little bit differently and the information is not comparable enough in the different clinics to give us a real notion as to what the optimum treatment actually is.

In addition to using the steroids we do have the problem of treating the edema, which is the thing that symptomatically bothers the patient the most, and whether we gain any ground in eliminating the albuminuria or not, at least sometimes we can get symptomatic relief by producing a diuresis. There are several mechanisms for doing this. You can depress the tubular reabsorption of sodium by giving mercurial diuretics or chlorothiazide or hydrochlorothiazide which has been tried in this patient. The mercurial diuretics have been effective many times in the past. In addition to these drugs which affect the tubular reabsorption of sodium, it is possible either to potentiate their effect or actually to get an effect independently by the use of plasma volume expanders. Since the basic lesion seems to be the loss of plasma volume from the loss of protein, you can physiologically correct this by administering protein in the form of serum albumin or

whole plasma or by giving Dextran®. These have different periods of life in the body: albumin is rather rapidly excreted in the urine, while Dextran® having different configuration and different molecular weights probably stays around a little bit longer in the body and may be a little bit more effective as a plasma volume expander under these circumstances. Both of these or any of these agents may at any time act by two means: by expanding plasma volume and renal plasma flow, they increase the glomerular filtration. At the same time by expanding the plasma volume they transiently over-expand it and the body can then afford to unload some salt and water because of the new increment of effective plasma volume. So these plasma volume expanders are useful themselves as diuretic agents and physiologically in improving the state of the circulation. They can be used to potentiate the effect of mercurials or chlorothiazide or sometimes of the cortisone itself. So the steroids may be used and lead to a partial diuresis, but the maximum effect of these may not be manifested in terms of diuresis until the plasma volume is expanded by the additional administration of plasma proteins, albumin, or Dextran®. It has often been my experience that the patient will go along ten or 15 days on steroids, fail to have a diuresis, and then after one unit of Dextran® or plasma, they'll have a big diuresis that may go on for days. Now, why once this diuresis is initiated it should continue, is one of the obscure factors that we really have no explanation for. I don't know why it lasts longer unless the oncotic reacting material really stays around to exert its effect.

At this point I want to emphasize one point about serum protein concentrations. You may see a patient have a massive diuresis in the nephrotic syndrome before the serum protein concentration has ever risen. The reason why it may not come up is that water has been drawn in from the interstitial spaces to dilute down the extra protein that is given, and while it has been effective in expanding the volume of plasma in the vascular compartment, it has not raised the concentration of protein very much. Indeed, if the concentration of serum protein when you give serum albumin goes up a lot, then that means that you have not been successful in imbibing fluid from the interstitial spaces and in accomplishing expansion of the plasma volume. So you must always remember that the serum albumin concentration is a ratio between the plasma water and the total amount of albumin in the vascular compartment, and that it is not a real reflection of the total amount of oncotic reactive material in the vascular compartment. You need not expect a 1:1

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correlation between the serum protein concentration and the diuresis which you're trying to achieve. It is quite common in the nephrotic syndrome to see the diuresis be virtually complete before the serum protein begins to rise. In other words, enough fluid has been brought into the vascular compartment by the proteins and excreted through the kidney to eliminate edema even though the total amount of protein present is not enough to give an entirely normal concentration.

The point that I think Dr. Wood wanted me to mention in the practical aspect of treating this patient is that she manifested a phenomenon that has been observed in nephrotics treated with steroids that has never been adequately understood. It has been noted in the literature by Luetscher, it's been noted by a number of other people I hear by word of mouth, and we've seen it occur under fairly well controlled conditions on metabolic balance wards, but not under circumstances where we could really study the physiology of it very well. As you start the nephrotic on steroids, a few of them, I would think, maybe one out of ten or 15 would show this sequence of events: the patient's urinary output instead of going up in the first few days of steroid therapy will fall off. They will begin to gain weight, maybe a kilogram for three or four days. After three days on steroids you check the serum sodium concentration and it has dropped by 10 or 15 milliequivalents per liter. In addition to that the patient's BUN or creatinine has gone up. Now what this seems to indicate to me is that upon initiation of therapy these people have had a sudden drop in their glomerular filtration rate. This is manifested by a drop in the urea clearance, the rise in BUN, and by a decreased excretion of water retention and a gain in weight. Since they are on a low sodium intake they can't go into positive sodium

balance, but most of these patients are not on restricted water intake. They continue to drink without putting out much water because of this acute drop in GFR, and the weight gain then leads to a dilution of their serum sodium.

This lady, I think, probably shows this. She weighed 68.5 kilograms on the day before prednisone was started, and after about five days her weight was up to 73 kilograms. During this period of time the urine sodium determination showed that she was putting out less than five milliequivalents per day on all of those days, but the drop in her serum sodium concentration was from 134 meq/l. down to 120 meq/l. She became hyponatremic during this period despite the fact that she was not wasting salt in her urine. This means then that this was a dilution hyponatremia. Concomitant with this weight gain her BUN rose from 25 to 38 mg. per 100 c.c., then to 45 and finally to 58 over about the first five days that she was on the cortisone, so this is our correlative evidence that she probably did have a rather acute drop in the glomerular filtration rate. As you look at the chart over the next four or five days the BUN came back down to 30 mg. per 100 c.c., her serum came back up to 132 meq/l., and her weight fell back down to 71 kilograms. She did not go back to the pre-cortisone level of 68.5, but she did have some diuresis. I don't know what the mechanism of this is, but the drop in glomerular filtration rate might be due to some pre-renal change in the circulation, a redistribution of blood flow so that a renal plasma flow is reduced under these circumstances. It might have something to do with the effect of cortisone on the inflammatory lesions in the glomeruli, thereby reducing the glomerular filtration rate, or it might have something to do with the interstitial pressures within the kidney that would affect the net filtration pressure under these circumstances. We just don't know what the intimate mechanism of this effect is. It does not happen in all patients, but if you know that it may happen, then it behooves you in treating the nephrotic with steroids to be prepared to restrict the water intake during the first four or five days of therapy so that they will not have a weight gain with the threat of congestive heart failure such as this lady showed. You can't prevent the drop in glomerular filtration or the rise in the BUN by restricting water, but you can prevent the disturbance of water and salt balance which leads to the hyponatremia and the increase of edema that occurs as they retain the water. If the BUN does not rise during this period of time you can rest assured that the glomerular filtration hasn't been modified and you can slack up on your restriction of water intake.

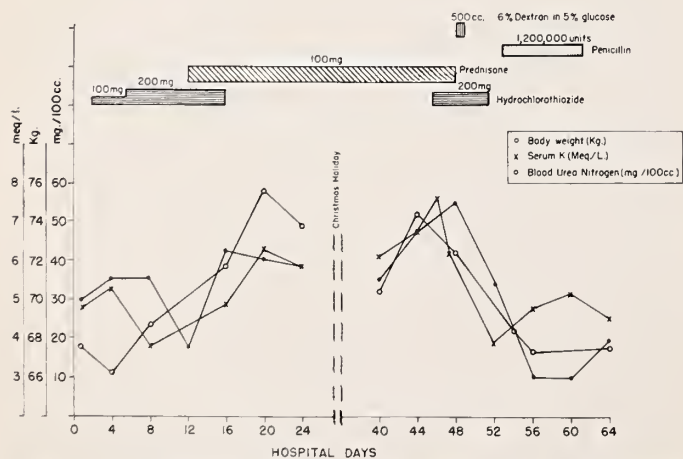


Figure 1: The hospital course of the patient with the nephrotic syndrome.

The second problem in her management has been the apparent relapse she underwent after her Christmas Holiday. She came back on the first of January, and immediately thereafter she "went to pot." The only change in her regimen was to take her off supplementary potassium because her serum level of potassium had risen to rather alarmingly high levels. She gained weight not only up to 73 kilograms but to 75 kilograms, and she developed distended neck veins, dyspnea, and orthopnea. She was in heart failure. I can't see anything that would have led me to anticipate this, and even in retrospect, I don't know why it did happen. This is one of the mysteries of the course of the nephrotic syndrome, and I just have to leave it unexplained. In any case, at the peak of her distress or maybe just a day or so later, Dr. Findley recommended a very brave thing: to go ahead and expand the plasma volume a little further by giving her the Dextran®. Apparently in response to that she really got a dramatic diuresis, even before the pneumonia became manifest.

If you superimpose upon the facts that you expanded her plasma volume with the Dextran® the fact that she developed an acute infection, this throws us back to 15 years ago when it was recognized that measles, for instance, might induce a diuresis in the nephrotic syndrome. We have since inferred that this might be a sort of endogenous dose of ACTH and adrenal steroids that produces this diuresis. It is probably a good deal more complicated than that. In any case, under the influence of her pneumonia and the expansion of her plasma volume, she had quite a good diuresis and went down to what she said was her dry weight. She was probably not completely dry because she most likely had lost some weight during her illness, but in any case she was in her best state as far as the water and salt retention was concerned at the end of her pneumonia. Also, whatever this phenomenon is with acute infection, it seemed likely to work pretty good magic on her urinary albumin excretion because it fell from peaks of about eight, 10, and 12 grams per day, back to about two grams per day. Now it has come up again and in the last few days she has shown evidence of albuminuria again and reaccumulation of fluid. I would think in handling her particular case that the thing to do now would be to start her back on fairly large doses of steroids. I would plan to maintain her on 80-100 mgm. of prednisone daily, even if we achieve a diuresis, for a period of at least three weeks and thereafter probably on intermittent doses. There is some evidence from the pediatricians in looking back over their series that those who were treated with larger doses for a longer period of time with the initial

episode have been the ones that have shown the longest remission and the highest percentage of complete remission, so we tend to shoot high rather than low in steroid treatment at the moment. I'd like to open this meeting to discussion now. This concept of the volume receptor and the mechanism of edema in the nephrosis is highly controversial, and the intimate mechanisms are still in the process of elucidation. There are a good many people that would take serious exception to what I've said and I would welcome comments or criticisms about it.

DR. WOOD: I enjoyed your comment on Dr. Findley's bravery. Let's enlarge on that a moment. We have some special information regarding this patient's vascular compartment. Without going into too much detail, we were able to measure the pressure-volume characteristics of the veins in her arms, that is to say the volume of blood that the veins of her extremities could hold at a given pressure before and after exercise relative to a normal individual. Shortly after she came back from her Christmas Holidays we diagnosed clinical congestive heart failure on the basis of elevated venous pressure, yet Dr. Jones says that she doesn't have murmurs, coronary artery disease, or any of the usual causes of heart failure. Does she really have it? She had, first of all, the standard methods of study. Her venous pressure was elevated at rest 16 cm. of water above the level of her right atrium; when she exercised the venous pressure went higher to 19 cm. of water. We were able to show that despite the fact that her blood volume was undoubtedly elevated, the veins were constricted. The muscles of the walls of the veins were actually working harder, making the compartment that Dr. Findley was worrying about tighter. When she exercised the veins become more constricted, which is abnormal. A normal individual simply doesn't do that with minimal exercise. In presenting her with a further volume of fluid, the question came up as to which way this was going

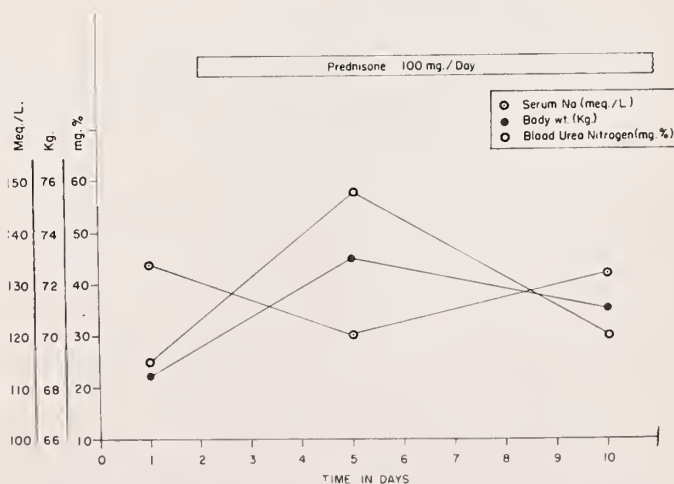


Figure 2: The initial effects of prednisone therapy in the nephrotic syndrome.

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to go. Would we expand her plasma volume to the extent that she would suffer acute symptoms of pulmonary edema, would she give us a real problem in therapy of that unfortunate complication of intravenous therapy, or would she, as a result, diurese quickly and reduce her blood volume? Should we consider the possibility of venodilating procedures, such as ganglionic blockade during an attempt to achieve an osmotic diuresis in a patient with an expanded blood volume and excessive venoconstriction should pulmonary edema occur to get them over this hump?

DR. TUTTLE: By conventional standards, if you find a patient with a venous pressure of 160 mm. with some dyspnea and a little bit of pulmonary congestion, you really are hesitant about giving them a blood volume expander. Yet with Dr. Wood's very acute understanding of how the venomotor system reacts under some circumstances, there was some theoretical reason to suppose that maybe with expanding the volume the compartment would expand with it spontaneously. Actually I would not have known which way to go. I think if I'd not had some experience with people on pressor amines, such as Norepinephrine, who show increased venous pressure but do well if you increase the blood volume and slack off on the administration of Norepinephrine, I would have been opposed to giving Dextran®. Knowing this, however, I think that we have reason to believe that this woman might respond in the right direction. As it turned out, the

steps that were taken were correct. If we had intervened by the means of giving a ganglionic blocker and dilating the venous compartment I think we probably could have blocked the diuresis. In other words, under these circumstances, by expanding the fluid in the right side of the heart and probably increasing the cardiac output even though she was approaching a limit, I think we actually induced a diuresis. If we had simply pooled this extra fluid in the venous compartment and had not forced the heart to work a little bit harder, we might not have seen the diuresis and the fluid might simply have remained in the body until such time as your ganglionic blockade wore off. So I think this is the calculated risk. Does the heart, which has no disease that we know of but simply seems to be under an acute load stress, have the capacity to increase its output a little bit further if we give it this Dextran®, and is that additional output enough to trigger off diuresis by (1) increasing the renal plasma flow or (2) by suppressing whatever the volume receptor mechanisms are which are misinterpreting the situation as a diminished blood volume. I'm not sure that her total blood volume was increased by any absolute standard. I think maybe it was high relative to the capacity of her vascular system (I'm really dubious that it was above the total normal volume). I think that these factors all play a role in the diuresis under these circumstances.

DR. FINDLEY: Well, I think the word Dr. Tuttle really wanted to use was not bravery but foolishness. I again want to thank him for spending this very interesting hour with us.

Medical College of Georgia

Annual Session of the Medical Association of Georgia

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A SHORT INTEGRATED TREATMENT OF TRICHOMONIASIS

Favorable results are reported with the use of Balarsen.[®]

James M. Burdine, M.D., *Atlanta*

THE ATTENTION OF THE PHYSICIAN is directed to specific or non-specific vaginitis most frequently by the patient's complaint of a flow of white purulent, odorous discharge from the vagina. A vaginal discharge is more frequently complained of than any other disturbance in my experience. Often the discharge is accompanied by mild or severe pruritus and irritation about the vaginal area. Since whiteness is not necessarily a common feature of the abnormal discharges from the vagina, the word leukorrhea is being used less and less and is being replaced by the more applicable term vaginal discharge. The term more properly covers all varieties of discharge regardless of color, though usually excluding those that are blood stained.

The blood free discharge in vaginitis may be acute or chronic. It is mostly with the latter type of discharge with which we are concerned here. The discharge must be differentiated from the normal physiological mucous discharge from healthy cervical glands. Hence one basic essential prior to treatment is a careful assessment of the history and physical examination. Often when the condition fails to respond to treatment, it is well to examine the male partner in the case of a married woman with a history of chronic discharge.

From the patients complaining of vaginal discharge with or without accompanying pruritus or irritation, a careful history must be taken to obtain as much information about the time and mode of onset, its quantity, color, and consistency; whether it is irritating, offensive or blood stained or any other special characteristic.

Examination should be carried out in a good

light. The patient is instructed to lie comfortably on her back with the thighs drawn up and separated. The labia are parted and the vaginal introitus is examined for the presence of discharge, signs of inflammation, ulceration, edema or other swellings. It is well to make a Papinicolau smear at this time. The urethral orifice should also be examined.

The patient should then be turned over on her side with her thighs drawn up, the upper one slightly more so than the lower, and a Sims speculum gently inserted into the vagina.

If a discharge is seen, a specimen diluted with saline should be inspected under the microscope for trichomonads or the spores and hyphae of thrush. The discharge is then removed with a swab and the vaginal walls are inspected carefully for redness, signs of abrasion, ulceration or other abnormality. The cervix is next examined for erosion and evidences of cervicitis and any excess of cervical mucus noted.

In most cases this examination will give information that agrees with the patient's complaints and should indicate the cause of the vaginal discharge.

A vaginal discharge may or may not be indicative of trichomonas. Often the vaginitis may be due to a mixed infection. In most cases, the examination combined with the history may reveal that the discharge and its accompanying symptoms are due to local causes; hence treatment should be directed to this end.

Many modalities have been used in the treatment of *Trichomonas vaginalis* vaginitis and non-specific vaginitis with a similar symptomatology. The drugs used have been legion, some applied as douches,

TRICHOMONIASIS / Burdine

suppositories or insufflation of powder. The drugs which have been in vitro trichomonacidal effect have had a limited amount of success largely, in my opinion, because they were not applied to all possible focal areas. Unless great care is taken to apply the drug to the creases and folds of the vaginal walls and other areas not reached by superficial topical application, recurrence is the common event. Consequently for over 14 months I have treated these types of vaginitis by a short therapeutic course. The feature of this was the application of the chemotherapeutic agent to the folds and creases in a systematic manner. This part of the treatment is performed in the office and is supplemented by insertion of suppositories for 6 or 12 consecutive nights.

Appended is a table of 10 of 50 unselected cases on which a positive diagnosis of *Trichomonas vaginalis* vaginitis was made. The ages ranged from 17 to 44 years. Noteworthy is a single case which was treated during pregnancy. Most of the cases cleared up after the first course of treatment and the remainder cleared after a second course of treatment. This treatment consisted of the application of Balarsen® suppositories in the following fashion.

This treatment is divided into two parts. The first part is the initial or office phase during which on the appearance of *Trichomonas vaginalis* vaginitis the vulva and vagina are thoroughly dry cleaned with cotton swab. Cotton tipped applicators saturated with Balarsen® solution are then used to paint the vagina and vulva systematically and completely. The second part, the follow-up or home phase starting with the night of the initial office treatment, the patient inserts one Balarsen® vaginal suppository high into the posterior vaginal fornix and at bedtime each night thereafter for a total of six nights. Upon the completion of the above, the initial or office phase

of therapy is repeated. A second course of treatment as outlined above is repeated if necessary.

Under these conditions most of the patients exhibit a diminution or cessation of the vaginal discharge and disappearance of the original complaint of pruritus and odor. Side reactions were very few and very mild, e.g., only a single case of rash in 50 patients was observed. The treatment received ready patient acceptance because of its shortness, simplicity, and readily observable benefits.

An incidental observation has been made with regard to recurrence of the infection. A case which had remained particularly free for several months showed a recurrence. This was cleared up again by a new course of treatment. This cycle of events was repeated a second time in the same pattern. The possibility that this was being repeated by sexual contact with her husband was explored and apparently proved to be the cause of the recurrence. The husband was treated by thoroughly cleansing the penis with warm water and thoroughly painting the crown of the penis with Balarsen® solution. In a second instance with a similar history, I found it necessary, in addition to the above treatment, to inject a 1:1 diluted solution of Balarsen® in propylene glycol into the urethral canal on two occasions. This observation points up the necessity of considering the spouse of any woman suffering from *Trichomonas vaginalis* as a candidate for treatment, both for himself and the eradication of a potential source of reinfection. This is particularly cogent in those cases where reinfection appears chronically.

Summary

- 1. Balarsen® (Arsthinol N.N.D.)* is a valuable trichomonacidal agent. Its effectiveness is directly related to its availability for topical application by means of the vaginal solution and suppositories, thus making it possible for the physician to strike directly at all possible foci.
- 2. Side reactions to the drug are rare. They are of a mild nature and clear spontaneously.
- 3. Most patients are microscopically cleared of organisms after a single course of treatment, and the

TABLE 1

Patients	Age	Pregnancy	Trichomonads Microscopically Demonstrated	Trichomonads After 1st Course	Second Course Required	Vaginal Discharge Decreased	Pruritus Absent	Odor Absent
1. A.R.	17	No	+	—	—	+	+	+
2. E.C.	34	No	+	+	+	—	—	—
3. B.L.C.	24	No	+	—	—	+	+	+
4. M.W.	22	No	+	—	—	+	+	+
5. J.P.	21	Yes	+	+	+	+	+	+
6. C.R.	32	No	+	—	—	—	—	—
7. J.W.	44	No	+	—	—	+	+	+
8. P.D.	18	No	+	—	—	+	+	+
9. J.D.	30	No	+	+	+	+	—	+
10. F.B.	40	No	+	—	—	+	+	+

Code: (+) Positive
(—) Negative

*Balarsen (brand of Arsthinol, NND, the condensation product of 3-acetamido-4-hydroxybenzenearsonous acid and dimercaprol (BAL).)

TABLE 2

Patient	Treatment Met with Patient Acceptance	Systemic Side Effects	Local Side Effects	Minimum Duration of Effects
1. A.R.	+	—	—	8 months
2. E.C.	+	—	—	"
3. B.L.C.	+	—	—	"
4. M.W.	+	—	—	"
5. J.P.	+	—	—	"
6. C.R.	+	—	—	"
7. J.W.	+	—	—	"
8. P.D.	+	—	—	"
9. J.D.	+	—	—	"
10. F.B.	+	—	—	"

Code: (+) Positive
(—) Negative

rest were negative after a second course of treatment.

4. Relief of vaginal discharge and pruritus and odor was very prompt and gratifying to the patients.

5. Several symptomatic recurrences were traced to reinfection by the spouse. These were rendered negative by the treatment of both husband and wife. No recurrence in a single reported case after a follow-up period of 8-12 months.

811 Hemphill Avenue, N.W.

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AMERICAN COLLEGE OF CHEST PHYSICIANS

AT THE ANNUAL MEETING of the Southern Chapter of of the American College of Chest Physicians, held in Atlanta, Georgia, November 15-16, 1959, the follow-ing officers were elected:

President: John H. Seabury, M.D., New Orleans, La.

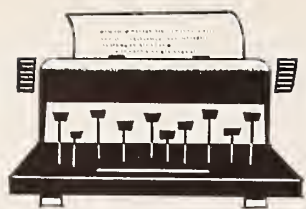
1st Vice-President: DeWitt C. Daughtry, M.D., Miami, Florida.

2nd Vice-President: Henry R. Hoskins, M.D., San Antonio, Texas.

Secretary-Treasurer: Joseph W. Peabody, Jr., M.D., Washington, D. C.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

Name	Address	Classification	County Society
Blissit, Joseph A.	169 Decatur Rd. McDonough	Active	Spalding
De Cardenas, Jose A.	847 Greenwood Ave., N.E. Atlanta 6	Active	Fulton
Douglas, John J.	303 Smith Street LaGrange	Active	Troup
Robert E. Jennings	City Hospital Arlington	Active	SW Georgia
Lassiter, Homer L.	Arlington City Hospital Arlington	Active	SW Georgia
Laupus, William E.	Talmadge Mem. Hosp. Augusta	Active	Richmond
McGee, Harry H., Jr.	7 Gordon Street, West Savannah	Active	Ga. Medical
Moreland, Robert H., Jr.	709 Bonnybridge Rd. Pt. Wentworth	Active	Cobb
Usher, Charles, Jr.	6 East Liberty St. Savannah	Active	Ga. Medical



editorials

A Pill for Ringworm

THE YEAR 1959 marked a major innovation in therapeutics in the discovery of the first orally effective drug for fungus infection of the skin.

At a recent conference on the new antibiotic, Griseofulvin®, which has been widely advertised for the treatment of fungus infections, we were exposed to an extensive and intensive biological, mycological, and clinical survey of this product.

Many facts were presented which may well explain its proper use in the treatment of "ringworm," and some facts which should dispel any fancies which are presently in the minds of the medical public.

Since Griseofulvin® will be given to patients who have the diagnosis of "ringworm," it may be well to explain what fungus infection is, and where in the body it occurs:

(1) Superficial infestation with fungi occur only in the keratin components of the skin, such as the outer hide, the hair, and nails.

(2) These fungi rarely (but may) involve deeper subcutaneous tissue.

(3) In general the fungi grow poorly in this media, and may easily be cultivated in vitro, and can be seen in this tissue by microscopic examination.

(4) They are of two main kinds: (a) trichophytons, or dermatophytons, and (b) yeast fungi, or monilia.

(5) The extent and rapidity of infestation occurs in direct proportion to the rapidity of growth of the keratin materials, and/or the warmth and dampness of the local climate conditions.

(6) These fungi are universal and their distribu-

tion occurs in floors, shoes, hair brushes, animals, and man, and occur on the feet in the absence of disease.

(7) Diagnosis can be assumed by clinical observation, but should be made by direct microscopic examination, or by culture.

Given the correct diagnosis then, Griseofulvin® is a remarkably efficacious drug in the relief of fungus disease, but by itself is not a cure-all for "ringworm."

The antibiotic, Griseofulvin® is a metabolic product obtained from several penicillin species of fungi. In the human body it is remarkably fungistatic, but not fungicidal. Griseofulvin® in sufficient concentration in keratin will produce degeneration of the fungal elements in the form of "curling" of the hyphae, but it fails to prevent germination of spores both in vivo and vitro situations. When given by mouth it seems to have an affinity for keratin, and can be recovered in large quantities from this tissue, but it is predominantly destroyed by the liver, more so than other tissues. It has a very low toxicity, and can be given in large quantities without producing tissue damage. The drug is readily washed from keratin and tissue by water and sweat.

Treatment Schedules: Large doses of Griseofulvin®, up to ten grams can be given, but probably any amount over one gram a day is wasted in destruction by the liver. The average dose is from one half to one gram daily for most fungus infections in man, and this dose is well tolerated by infants. The drug is deposited in keratin within ten to 12 hours after ingestion, and in three days in such quantities

itching is often relieved. But since "washing out" occurs in the tissue, continued ingestion must occur for "cure" to take place.

Criteria for cure are difficult, if not unable to come by. Term of "clinical cure" is dependent on the level of Griseofulvin® concentration in the tissue, and the rate of growth and desquamation of the particular keratin involved. Treatment, therefore, must be consistent for many weeks, *six to eight* in infection of the *hair*, plus the repeated cutting of the hair; for many months, *three to six*, for *nail* infestations; and for fewer weeks, *three to four*, for infestations of the *glaborous skin*.

It may be presumed that of now that: (1) *tinea capitis* and *tinea corporis* are curable with Griseofulvin®, in time, (2) *tinea unguium* may be curable in a longer time, (3) deeper trichophyton infections are not curable, but are immensely relieved, (4) Griseofulvin® does not change the resistance to infection, and therefore does not prevent recurrence, (5) the drug is of no value in any of the infections due to monilia (yeast), or monilia-like (yeast-like) fungi, and (6) this drug is by no means a cure-all, but is the first and only orally effective therapy for superficial fungus infections.

Nucleic Acids and Medicine

IN 1958 THE NOBEL PRIZE in medical science was awarded Dr. George Beadle, California Institute of Technology, Dr. Joshua Lederberg, Stanford University, and Dr. E. L. Tatum of the Rockefeller Institute. In the following year, 1959, the award was shared by Dr. Severo Ochoa, New York University, and Dr. Arthur Kornberg of Stanford University. Perhaps at no time in recent years have successive awards so dramatically signalled or presaged the advent of a new approach or insight into the understanding of the disease process.

In some ways the first loop of a spiral has been completed, a spiral whose tracing was first begun some 50 years ago by Archibald Garrod, who proposed a concept of inborn errors of metabolism—diseases in which an individual's metabolic processes are deficient in their capacity to utilize intermediate products in the metabolism of a substance.

The Nobel Laureates Beadle and Tatum in biochemical studies on the metabolism of mutants of *Neurospora*, a bread mold, have broadened remarkably the understanding of the interrelationship of genetics and chemical reactions carried on within the cell. They have proposed a general concept, now widely accepted, that a single gene can be involved in a single metabolic reaction. This reaction is under control of the gene and any alteration or mutation of this gene will effect a corresponding metabolic

change. A specific gene defect is related to an inability of the cell to synthesize a specific enzyme, which may be one link in a series of catalytic transformations of a substance within the cell. Here one finds an expression of the relationship of inheritable characteristics to biochemical individuality. Dr. Garrod's conclusions in regard to alkaptonuria were verified many years later by the demonstration that the accumulation of homogentisic acid and its excretion in the urine is associated with a lack of homogentisic acid oxidase, an enzyme necessary for the metabolism of homogentisic acid in the breakdown of tyrosine and phenylalanine in the body.

Just how the specific structure of genes determines the detailed reactions of metabolism is a difficult question. There is considerable evidence that genes are nucleoproteins and that genetic transmission is accomplished by a specific nucleic acid present in the chromosomes of the nucleus of cells. In biochemical terms this nucleic acid must possess two fundamental properties of the gene, ability to reproduce, and mutability. In regard to the former property the studies of Dr. Kornberg and his co-workers have brilliantly illuminated our knowledge of the steps in the enzymatic synthesis of deoxyribonucleic acid. With enzymes isolated from microorganisms and regenerating liver, they were able to demonstrate a net synthesis of this nucleic acid. The synthetic product

very closely resembles that found normally in cells. A very small amount of preformed nucleic acid is necessary to prime the synthesis. Of great moment was the observation that primers derived from different species promoted the synthesis of a deoxyribonucleic acid that resembled not that usually found in cells from which the enzymes were derived, but rather a nucleic acid resembling the added primer. There is here a beginning of an understanding of how foreign directive or mutagenic agents such as viral and carcinogenic substances may profoundly alter cell characteristics.

There must be some mechanism by which genes and deoxyribonucleic acid translate inheritable characteristics in terms of biochemical individuality, or more specifically, in terms of the biosynthesis of specific enzyme protein responsible for specific biochemical reactions. Evidence suggests that deoxyribonucleic acid guides the synthesis of another nucleic acid found in cells, ribonucleic acid, which in a direct manner regulates enzyme protein synthesis. Dr. Ochoa and his collaborators have dramatically demonstrated the mechanism by which ribonucleic acid may be synthesized in the cell.

The manner in which ribonucleic acid regulates protein synthesis is now under investigation by a number of laboratories. It is known that low-molecular weight ribonucleic acids present in the cytoplasm

act as specific carriers for each amino acid, and that in this form the amino acids are transferred to a high-molecular weight ribonucleoprotein present in the microsomes of the cytoplasm. At this site the amino acids are conjugated and polymerized to a protein. The protein synthesized bears a direct relationship to the type of high-molecular weight ribonucleic acid present, the nature of which is governed by biochemical characteristics of the genes and deoxyribonucleic acid of each cell. From what is now known it is possible to envisage the qualitative and quantitative changes in the nature of enzyme protein that may be induced at both nuclear and cytoplasmic level.

To the physician the implications of these results are revolutionary. They not only give basic understanding to the mechanism by which inheritable metabolic errors may be produced, but as our knowledge of the interrelationship of deoxyribonucleic acid, ribonucleic acid, and protein biosynthesis advances, the physician will be able to perceive the discipline of medicine at a "molecular level," and to apply the knowledge obtained from the study of the grossly qualitative abnormalities to metabolic problems, which represent quantitative deviations from the normal, as well as to achieve a more rational basis of therapy. It is hoped that in the near future the understanding and treatment of degenerative and neoplastic diseases will profit from this realm of rationality.

S. A. Singal, M.D.

VASCULAR STAPLING DEVICE

DEVELOPMENT OF A STAPLING device that enables the surgeon to join blood vessels together rapidly with tiny staples of stainless steel was announced by the Veterans Administration recently at the agency's annual Medical Research Conference in Cincinnati, Ohio.

The research on the stapling device was supported in part by the American Heart Association. Dr. John G. Hood, director of the VA's seven-state Area Medical Office in Atlanta, said in announcing the revolutionary process developed at one of the hospitals under his supervision.

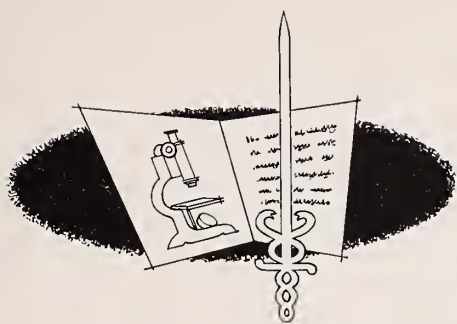
Dr. Timothy Takaro, chief of the cardiovascular section at the Oteen, N. C., VA hospital and chief investigator in the project, says the instrument consists of but eight parts, in contrast to a much more complicated

and bulky Soviet vascular stapling device, which is composed of 26 or more parts.

Dr. Hood said the stapling device developed at the Oteen VA hospital has been tested successfully in animals more than a dozen times but has not yet been used for humans.

Grafts of dacron have been used to replace one of the main blood vessels, the thoracic aorta, with the aid of the device, and the Oteen group is preparing smaller models of the stapling device for use on tiny blood vessels.

It is hoped the smaller models will materially facilitate work on transplantation of body organs, which requires technically perfect surgical joinings of blood vessels, Dr. Takaro reported to the group.



cancer page

FOURTH NATIONAL CANCER CONFERENCE

A. H. Letton, M.D., *Atlanta*

“CHANGING CONCEPTS CONCERNING CANCER” will be the theme of the Fourth National Cancer Conference to be held at the University of Minnesota, Minneapolis, September 13-14-15, 1960.

Sponsored by the American Cancer Society and the National Cancer Institute, the Conference will feature internationally known physicians and scientists as speakers, panel chairmen, and participants.

General sessions will be held during the mornings and symposia during the afternoons. The former will include addresses on “Changing Concepts Concerning Cancer,” “Frontiers in Biology and Cancer Research,” and “Care of the Advanced Cancer Patient,” as well as panels on “Cancer Etiology,” “Cancer Pathogenesis and Spread” and “Cancer Therapy.” Symposia will be devoted to cancers of the breast, lung, female genital tract, gastro-intestinal tract, male genitourinary tract, skin, head and neck, and to the leukemias and lymphomas. There will also be a symposium on cancer control.

The final session of the Conference will be the Summary Session. Each of the Summary Session participants will have audited a panel or symposium for the special purpose of reporting at this final

meeting. From this would emerge a sound concept of where we stand in cancer—whether present beliefs are based on firm facts; what new data we have that may require modification of presently accepted concepts; what new research needs to be initiated, etc.

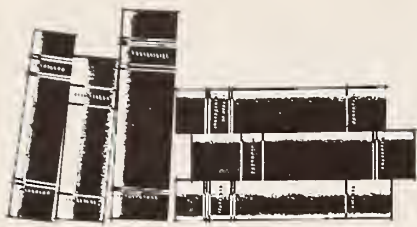
To attract as many young research workers, residents, interns and medical students as possible, arrangements have been made to utilize the dormitories at the University. These accommodations will be available at very reasonable rates. This is an unusual opportunity to bring this particular group of people to the Conference and one that we would like to see utilized to the maximum.

For further information on the Conference, please write to:

Medical Affairs Department
American Cancer Society
521 W. 57th Street
New York 19, N. Y.

If the desired information is not received within a reasonable time write or call Georgia Division, American Cancer Society, 2025 Peachtree Road, Atlanta 9, Georgia.

Approved by Professional Education Committee, Georgia Division, ACS.



physician's bookshelf

BOOKS RECEIVED

Johnson, Harry J., M.D., **THE LIFE EXTENSION FOUNDATION GUIDE TO BETTER HEALTH**, Prentice-Hall, Inc., New York, N. Y., 1959, 220 pp., \$4.95.

Kevorkian, Jack, M.D., **THE STORY OF DISSECTION**, Philosophical Library, Inc., New York, N. Y., 1959, 80 pp., \$3.75.

Guttmacher, Alan F., M.D., **BABIES BY CHOICE OR BY CHANCE**, Doubleday & Co., Inc., New York, N. Y., 1959, 289 pp., \$3.95.

Gordon, Benjamin Lee, M.D., F.I.C.S., **MEDIEVAL AND RENAISSANCE MEDICINE**, Philosophical Library, New York, N. Y., 1959, 843 pp., \$10.00.

Welch, Henry, Ph.D., **A GUIDE TO ANTIBIOTIC THERAPY**, Medical Encyclopedia, Inc., New York, N. Y., 1959, 69 pp., \$3.00.

Ochsner, Alton, M.D., F.A.C.S., and DeBakey, Michael E., M.D., F.A.C.S., **CHRISTOPHER'S MINOR SURGERY**, W. B. Saunders Co., 1959, 539 pp., \$10.50.

Welch, Henry, Ph.D., and Finland, Maxwell, M.D., **ANTIBIOTIC THERAPY FOR STAPHYLOCOCCAL DISEASES**, Medical Encyclopedia, Inc., New York, N. Y., 1959, 208 pp., \$4.50.

Ochsner, Alton, M.D., **SMOKING AND HEALTH**, Julian Messner, Inc., New York, N. Y., 1959, 108 pp., \$3.00.

King, Arthur, **THE CIGARETTE HABIT: A SCIENTIFIC CURE**, Doubleday & Co., Inc., New York, N. Y., 1960, 96 pp., \$2.00.

REVIEWS

Blank, Harvey and Rake, Geoffrey, **VIRAL AND RICKETTSIAL DISEASES**, Little, Brown and Company, Boston, Mass., 1955.

THIS HANDY VOLUME is the first detailed treatise on the many cutaneous viral diseases. The authors, one a practicing dermatologist, and one a virologist, have co-operated in making it a happy combination of personal knowledge and laboratory data. The viral diseases, some of which are more troublesome than serious, are nevertheless quite adequately described and illustrated. The chapter on warts is worth the cost of the book, and thus can be highly recommended for the dermatologist as well as the internist.

The book should be on the desk of the general prac-

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

itioner and in the library of all physicians engaged in public health activities.

Herbert S. Alden, M.D.

Lipman, Bernard S., A.B., M.D., F.A.C.P., and Massie, Edward, A.B., M.D., F.A.C.P., **CLINICAL SCALAR ELECTROCARDIOGRAPHY**, The Year Book Publishers, Inc., Chicago, Ill., 1959, 474 pp.

THIS BOOK APPEARS to be an up-to-date, straightforward presentation of the basic knowledge of electrocardiography. All of the necessary information is included to make it possible for a beginner to learn how to interpret electrocardiographic tracings. Although the discussion has been kept relatively brief, the subject matter has not been slighted. Very little controversial material has been included. Some physicians would object to the author's recommendation that a double two-step Master's Test be done from the first. However, he does caution the patient against the dangers. The chapter on congenital heart disease is very brief and almost telegraphic but no really important electrocardiographic material is left out. There is a good section on the P wave. Vector electrocardiography is briefly discussed with many illustrations borrowed from Hurst and Woodson. Sufficient illustrative electrocardiograms are included. Several helpful tables are also included. In conclusion, this is a useful textbook or handbook for the individual concerned with the interpretation of electrocardiograms.

Arthur M. Knight, M.D.

Long, Rowland H., **THE PHYSICIAN AND THE LAW**, Appleton-Century-Crofts, Inc., New York, N. Y., 1959, 302 pp., \$5.95.

THIS BOOK, WRITTEN BY a lawyer and a teacher of Forensic Medicine, is a readable and easily understood document for the medical profession. It goes into every aspect of the physicians contact with the courts and law as relates to his practice of medicine. It explains the courts' interpretation of the law with illustrated cases. It answers most of the questions that any practicing physician needs to know in this field. It is accurate as far as my legal research can determine.

Henry Finch, L.L.B., M.D.

Havener, William H., M.S. (Ophth.), **SYNOPSIS OF OPHTHALMOLOGY**, The C. V. Mosby Co., St. Louis, Mo., 1959, 288 pp., \$6.75.

WITH THIS SMALL, NEAT, and concisely written volume Doctor Havener presents the observations and experi-

ences of a practicing ophthalmologist that help the physician with his eye problems of diagnosis or management. A quick consultation and practical viewpoint is thus afforded, and may mean the difference between a well-treated seeing eye and visual tragedy.

Concepts of management of the red eye and eye injuries will give the Intern or Resident in emergency new confidence, and the section on strabismus presents accepted ideas and a glossary that should be of value in discussing children's eye problems. The ocular therapy is up to date, and case-history examples present the work-up routine that is highly desirable.

This book fulfills a need for practical management in eye cases; and, though called a synopsis, is a volume completely worthwhile.

W. Granville Tabb, Jr. M.D.

Leigh, Ted F., M.D. and Weens, H. Stephen, M.D., THE MEDIASTINUM, Charles C. Thomas, Publisher, Springfield, Ill., 1959, 246 pp., \$11.50.

THIS IS AN EXCELLENT publication on disease of the mediastinum with particular reference to the radiographic approach to the examination of the mediastinum. The chapter on Anatomy is well acceptable and portrays in excellent pictures the general divisions of the mediastinum, and the structures passing through these divisions. All lesions of the mediastinum are discussed thoroughly. We were especially impressed with the section on the lymph nodes and thymus. It is so common to find this group of lesions being missed on routine studies with patients, that it is felt this chapter is of considerable importance to all those people practicing in any of the fields of medicine. The more common lesions are handled in an interesting and complete fashion. Many of these lesions have some specific diagnostic points which are brought out completely and adequately in this book.

The chapter on vascular lesions of the mediastinum including the aorta, pulmonary artery and its branches is most appropo to this particular period of medicine. Since we know now that these lesions are amenable to surgical correction it is certainly important that all physicians be cognizant of the characteristics of these mediastinal shadows. Although this book is mainly directed toward the radiographic diagnoses of these very interesting lesions it is one that almost any physician should have in his library as it is a particularly excellent reference book. There is an excellent bibliography following each chapter from which one can delve further into the literature for increased knowledge in regards to any particular type of lesion. It would seem to me that this book is a must for medical students and those still in their training period as it presents in a clear and concise method all of the lesions encountered in the mediastinum.

William A. Hopkins, M.D.

Wilson, Robert Cumming, DRUGS AND PHARMACY IN THE LIFE OF GEORGIA, Foote & Davies, Inc., Atlanta, Ga., 1959, 443 pp., \$6.00.

Dr. Wilson has compiled and written a monumental work. He and his research staff have gathered together from original sources a vast storehouse of exact information concerning the life of the people of Georgia.

The contents of the book are so important that I think they should be enumerated here:

"I. Reason for the establishment of the Colony of Georgia—the search for drugs a prominent factor.

"II. The founding fathers of the profession of pharmacy and medicine in Georgia.

"III. Disease and drug problems confronting the Colony.

"IV. Self-diagnosis of ordinary and epidemic diseases became a necessity in the life of the Colony and of the State, 1733-1807.

"V. With the appearance of newspapers in Georgia in 1763, the value of advertising is discovered and is promptly adopted by those having medicinal products or medical services to offer the public, 1763-1820.

"VI. Public health organizations, medical and pharmaceutical education, and legislation begin a slow but definite process of evolution, 1760-1828-1959.

VII. The retail drug store in Georgia—past and present.

"VIII. Specialized fields of pharmacy—wholesale and manufacturing, the professional store (the Apothecary Shop), hospital pharmacy, education, and research.

"IX. The soda fountain—soda water: at first a medicinal agent, becomes a beverage.

"X. Ether anaesthesia, 1842, and Coca-Cola,[®] 1886: born in Georgia drug stores. A story whereby Coca-Cola[®] becomes the complement of ether anaesthesia.

"XI. Drugs and the modern era."

The four supplements, six appendices and bibliography form an invaluable source of ready reference for the student of history. The supplements cover the field of medical education and pharmaceutical education, laws governing the practice of medicine and pharmacy, 1825-1958, and the Georgia Pharmaceutical Association and The Woman's Auxiliary.

The appendices give in detail a glossary of terms and formulas of a period, 1733-1800, some drugs used by the American Indians, list of drugs for filling medicine chests or boxes, diseases transmittable from certain domestic animals to man, members of the Georgia State Board of Pharmacy, 1881-1958, and a medical fee bill of vintage 1865.

In this great work Dr. Wilson has stressed the facts that:

1. Drugs, next to food, are the most important item in the life of a people.

2. The importance of drugs justifies and demands continuous and extensive research in drugs—by trained specialists.

3. That diseases of animals, and vegetation are, in addition to human diseases, controllable by drugs.

4. That progress in drugs and medicine has come as the result of specialization.

5. That drugs must be distributed through those agencies directed by specialists in the field of drugs who recognize their dangers as well as their values.

6. A health team for Georgia should be organized so as to pool knowledge of all specialized fields in the interest of the public health and welfare.

Dr. Wilson's great book furnishes a wealth of information, a source of historical facts, and a ready reference storehouse of Georgiana for all times.

Allen H. Bunce, M.D.



HIGH OUTPUT CIRCULATORY FAILURE

Dan Burge, M.D., *Atlanta*

IN CHRONIC CONGESTIVE heart failure the cardiac output, at rest, is usually below "normal" or within normal range, and peripheral resistance is increased. In other patients with the symptoms of congestive heart failure the cardiac output is *increased*. Such patients may have severe anemia, beri-beri, hyperthyroidism, advanced pulmonary emphysema, large arteriovenous fistula, patent ductus arteriosus, advanced osteitis deformans, or pregnancy. These conditions have in common an increased tissue need for blood. This is met by an increased speed of circulation, provided by increased cardiac output. In these conditions the *mean* arterial pressure remains normal. The systolic pressure is raised and the diastolic lowered. The peripheral resistance to the flow of blood is proportional to the mean blood pressure and inversely proportional to the cardiac output. Therefore in high output failure the peripheral resistance is diminished. Lowered resistance in severe anemia, beri-beri, hyperthyroidism, and severe emphysema with hypoxemia is thought to be due to incomplete oxidation of carbohydrate. This results in accumulation of intermediate metabolites which cause vasodilatation. In A-V-fistula and patent ductus arteriosus the lowered resistance is due to the run-off of arterial flow through a shunt. In advanced osteitis deformans and pregnancy the peripheral resistance is lowered by passage of large volumes of blood through rich vascular beds which act as shunts.

Lowered resistance is the apparent stimulus inducing increased heart output.

In this group of conditions with symptoms of congestive heart failure there are, then, two features contrary to the case in "ordinary" cardiac decompensation. These are increased cardiac output and lowered peripheral resistance. Some workers have belittled the heart as a factor in the causation of high output circulatory failure. However, several facts tend to implicate the heart. The conditions associated with high output rarely induce congestive failure except in the presence of coexisting heart disease of other etiology. This is particularly true in hyperthyroidism and anemia. Even in long standing A-V-fistulas, coronary artery or valvular disease may help to induce decompensation. Furthermore, during high output failure cardiac output is high, but lower than it was in the same patient prior to failure. Hence, it may be said that output tends to fall and resistance tends to increase in cardiac decompensation regardless of whether the output is low, normal, or high compared to absolute standards.

Wide pulse pressure, bounding pulses, normal or short circulation time in congestive failure should cause the physician to suspect high output. Each of the possible causes should be considered. Unsatisfactory response to digitalis should further arouse suspicion.

In chronic anemias with a hemoglobin of 7.0

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

grams or less, high output failure may develop. Less severe anemia may be sufficient if coincident heart disease is marked. Beri-beri is suggested by a history of dietary deficiency or chronic alcoholism, and by evidence of peripheral neuritis. Hyperthyroidism should be suspected in every case of chronic congestive failure. The physician's attention is easily diverted from the subtle clues of hyperthyroidism by more marked ones of decompensation. The ability to control the latter condition depends, however, on recognition and treatment of the thyroid disease. In pregnancy cardiac failure may be difficult to diagnose because fatigue, dyspnea, tachycardia, and edema may be due to pregnancy. Cardiac enlargement may be confused with transverse heart position from a high diaphragm. Murmurs heard may be caused by hemodynamic changes in pregnancy or by heart diseases. A-V fistulas may be congenital or acquired. A penetrating wound involving adjacent artery and

vein is the most common cause. A wound scar with nearby continuous murmur and thrill is usually found. In a few cases of chronic pulmonary emphysema high cardiac output may develop as a compensation for poor oxygenation of blood. Right ventricular failure from rising pulmonary hypertension is far more common in such cases. Patent ductus arteriosus usually makes itself evident by typical continuous murmur. Osteitis deformans would ordinarily have been correctly diagnosed before high output failure resulted from it.

Usually hyperthyroidism, beri-beri, acquired A-V fistulas, and patent ductus can be successfully treated. The same is true of many severe anemias and congenital A-V fistulas. High output failure should be considered whenever heart failure is found. When diagnosed, its precipitating cause should be carefully sought, since it may be eliminated in the majority of instances.

EVERYONE SHOULD BE A POLITICIAN

POLITICS MAY BECOME almost unanimously popular in this country, and when the day comes that most Americans consider political activity properly within the realm of all citizens, then most of our governmental problems should become much more manageable.

A heartening trend toward regarding politics as a vital part of every citizen's everyday life has been indicated by some "straws in the wind" of recent years.

The most notable development has been the increased activity of businessmen in political affairs. The business leaders of a few years ago were generally regarded as looking upon politics as a dirty word, period. Aspiring junior executives were advised that "business and politics don't mix."

Of course, this sorry regard for political activity was a sure sign that politics was in need of the very men who were shunning participation. Now, an assessment of the general business attitude toward politics by *Fortune* magazine reveals that politics is the extracurricular activity most ardently pursued by businessmen today.

And the president of the American Medical Association, Dr. Louis M. Orr of Orlando, Fla., has urged the nation's doctors to take a more active interest in the whole area of politics, public affairs, and community life. Dr. Orr says doctors can not pass their political responsibilities to others. He explains the necessity for

doctors to engage in political and public affairs as follows:

"A physician cannot . . . divert his gaze from the social, economic, and political issues which affect the practice of medicine. Politics is not an activity that should be entrusted to the venal or the second rate. Nor is the word 'politician' a term of opprobrium. Therefore, I think we have a double duty—as physicians and as citizens—to take an even more active part in the political and civic life of our nation, state, and community."

Dr. Orr is blunt in stating that doctors have a professional interest in politics. And businessmen too have found that political activity is desirable to gain the goals which will benefit their interests.

And that is a lesson every voting-age citizen should heed: a group should look out for its own interests; it is too much to expect that someone else will do it. This is true not only of groups but of individuals.

The first prerequisite of political activity, of course, is registering and voting. That is basic.

We are encouraged by the "straws in the wind" which indicate an awakening of political interest in the country. Particularly gratifying is the defense of politics as such, the rebuttal of the false notion that political activity is somewhat less than desirable.

—Savannah Morning News

current clinical concepts

The Weber-Christian Syndrome

TWO PATIENTS WITH RELAPSING febrile nodular nonsuppurative panniculitis (Weber-Christian Syndrome) had long-lasting remissions following the administration of chloroquine diphosphate.

Meyers, W. K.: *Ann. Int. Med.* 1959, 51: 791.

The Action of Digitalis

THE MODE OF ACTION of digitalis is still perplexing. We know that it has no action in the normal or even in the hypertrophied heart that is measurable by our present clinical hemodynamic methods. Its action was most often demonstrable in left ventricular failure, particularly in hypertensive or ischemic heart disease. Sometimes one could see a marked increase in right ventricular pulse pressure following the administration of digoxin. On other occasions little seemed to happen. In still other instances, following improved function of a failing left ventricle which cleared engorgement of the lungs the right ventricular pulse pressure would fall. It is almost impossible to predict the metabolic state of the heart on which digitalis may exercise its action. Every time digitalis is given its administration is something of an experiment. When the experiment is successful the results are dramatically good; even when they are less striking, we cannot deny that the drug may have had some action outside the range of our present method of measurement. On still other occasions it may indeed have no beneficial action at all. So long as overdosage is avoided, however, it probably does no harm, and its continued administration to most cardiac patients is probably advisable.

McMichael, J.: *Ann. Int. Med.* 1959, 51: 635.

Potassium-Losing Nephritis

PRIMARY RENAL DISEASE causing potassium deficiency is often associated with a systemic acidosis owing to inadequacy of excretion of hydrogen ion, e.g. in renal tubular acidosis, the Fanconi syndrome,

and in cases of uretero-sigmoidostomy. These cases are readily distinguished from primary aldosteronism. In some cases of chronic pyelonephritis or renal ischemia there may be potassium deficiency with hypokalemic alkalosis closely resembling cases of primary aldosteronism. The diagnosis is made more difficult by the fact that irreversible renal disease may often develop secondarily in cases of primary aldosteronism. Severe prolonged potassium deficiency causes characteristic lesions in renal tubular cells with vacuolation and progression to cell necrosis. There is considerable evidence that these lesions predispose to chronic pyelonephritis which converts the previously reversible lesion to one which is permanent despite adequate potassium repletion.

Milne, M. D.: *Clinical Effects of Electrolyte Disturbances*, J. B. Lippincott Co. 130, 1959.

Adynamia Episodica Hereditaria

IT SEEMS LIKELY that the type of periodic paralysis resistant to potassium treatment and having an apparently normal serum potassium concentration may be examples of this rare condition. Clinically the attacks are very similar to those of the hypokalemic hereditary type, the main differences being:

- a. the attacks are much shorter
 - b. they date from infancy instead of starting at about the age of 10 years
 - c. they usually occur within 20-30 minutes after sitting down after exercise instead of that night
 - d. attacks are not brought on by a high carbohydrate intake
 - e. attacks can be induced by potassium chloride.
- The serum potassium concentrations tend to rise rather than fall during an attack, although it is evident that there can be significant weakness while the serum potassium concentration was still within normal limits. Complete quadriplegia occurs at levels between 6.5 and 8.0 mEq/l. . . . the urinary excretion of potassium with rare exceptions rises during attacks, in contrast to the low excretion during hypokalemic attacks.

McArdle, B.: *Potassium Paresis*, J. B. Lippincott Co. 104, 1959.

Management of the Patient Who Fails to Void After Operation

URETHRAL CATHETERIZATION is usually unnecessary after surgery but should be done by the attending physician only if the patient has not urinated voluntarily and has a full bladder.

Myron H. Nourse, M.D., J.A.M.A., Nov. 28, 1959, Vol. 171: No. 13.

Albuminuria and Hematuria in Boxers

THE APPRECIABLE INCIDENCE of albuminuria 15 per cent and hematuria 28 per cent in a study of amateur boxers would suggest that all boxers amateur and professional alike should be required to have a urinalysis as part of the routine examination preceded-

ing a match, in order that the pre-existing renal abnormalities might be detected prior to strenuous exercise.

Capt. Frank B. Flood (MC), U. S. Army (Res.), J.A.M.A., Nov. 21, 1959, Vol. 171: No. 12.

Male Pseudohermaphrodisism

THE USE OF LARGE doses of estrogens in the early course of fetal development is perhaps the explanation for the development of male pseudohermaphrodisism. It is probably unwise to give in the early weeks of pregnancy large doses of estrogens.

Captain Norman M. Kaplan, MC, USAF, The New Eng. Jour. of Med., Sept. 24, 1959, Vol. 261: No. 13.

Management of Ureteral Injuries

IT WOULD BE HARDLY necessary to repair ureteral injuries if the general or gynecological surgeon would routinely perform x-ray outline of the urinary tract, and perhaps more important have indwelling ureteral catheters inserted before surgery.

William J. Staubitz, M.D.; Imre V. Magoss, M.D.; Melbourne H. Lent, M.D.; Eugene M. Sigman, M.D. and Oscar J. Oberkircher, M.D., J.A.M.A., Nov. 7, 1959, Vol. 171: No. 10.

Extracorporeal Perfusion with Chemotherapeutic Agents

IT IS POSSIBLE TO administer nitrogen mustard and allied compounds in tumorocidal doses without too deleterious effect on the gastrointestinal and hematopoietic systems. The region bearing a tumor can be perfused once the remainder of the body is isolated. Occlusion of the aorta and vena cava and the

femoral vessels in both lower extremities permits perfusion through the femoral vessels via plastic cannulas.

W. Gerald Austen; Anthony P. Monaco; George S. Richardson; William H. Baker; Robert S. Shaw, and John W. Raker, The New Eng. Jour. of Med., Nov. 19, 1959, Vol. 261: No. 21.

Profession or Business?

BECAUSE THERE HAS BEEN in recent years an overlapping between the profession of medicine and business, it would be well for every physician to remember that the profession of medicine is organized for service to humanity whereas business is entered into for the sake of material profit.

J. H. Means, M.D., The New Eng. Jour. of Med., Oct. 15, 1959, Vol. 261: No. 16.

Bronchogenic Carcinoma in Young Persons

THE MANIFESTATIONS OF bronchogenic in young and old persons have been regarded as widely different, the variations possibly representing the effect of different causal mechanisms. The literature revealed a report of 60 cases in patients under the age of 21 and the author reports two additional cases and the third in a young man of 22. Observations suggest that in bronchogenic carcinoma of young persons there is a preponderance of peripheral growths and a relatively shorter duration of life after the onset of symptoms.

W. J. Hanbury, St. Bartholomew's Hospital, London, England, British Journal of Cancer 12: 202-206, 1958.

A.M.A TO SPONSOR FOUR CONFERENCES ON AGING

THE AMERICAN MEDICAL ASSOCIATION has announced that it will hold a series of four regional conferences on aging during the first quarter of 1960.

Sponsored by A.M.A.'s Committee on Aging and 19 local medical societies, the conferences will be attended by representatives of agriculture, industry, labor, health professions, churches, schools, business, government, women's organizations, communications media, and civic organizations.

Dates and locations of the meetings are: Feb. 17-18, Roosevelt Hotel, New Orleans; March 7-8, Dinkler-Plaza Hotel, Atlanta; March 30-31, Southern Hotel, Baltimore.

In announcing plans for the conferences, Dr. Frederick C. Swartz, Lansing, Mich., said, "We need to explore the opportunities for positive health and meaningful living among older people through exercise of individual, group, and community initiative.

"With nine per cent of the nation's population now over 65 and the percentage increasing, it is important for every American to give thoughtful consideration to the aging process and its implications—to individuals and society alike."

According to Dr. Swartz, who is chairman of the

A.M.A. Committee on Aging, specific objectives of the conferences are:

—To appraise the significance of the longer life span and its impact on individuals and society.

—To analyze relationships between social, economic, psychological, and physiological factors and the health of older persons.

—To realistically explore the opportunities and needs created by a growing population of older persons.

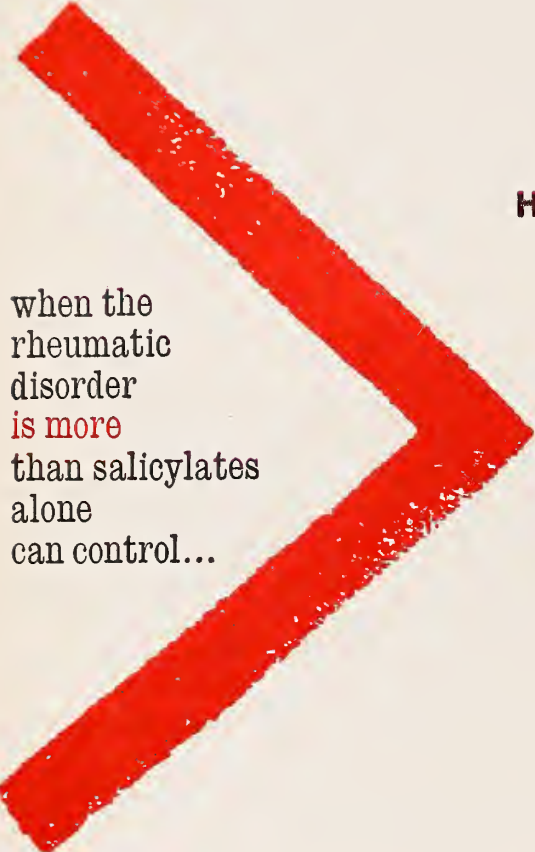
—To assess responsibilities of the individual and of both medical and non-medical groups in dynamic approaches to the new era of aging.

Three west-coast medical societies will co-sponsor the San Francisco meeting. These include Washington, Oregon, and California.

State societies participating in the New Orleans conference are Texas, Arkansas, Louisiana, and Mississippi.

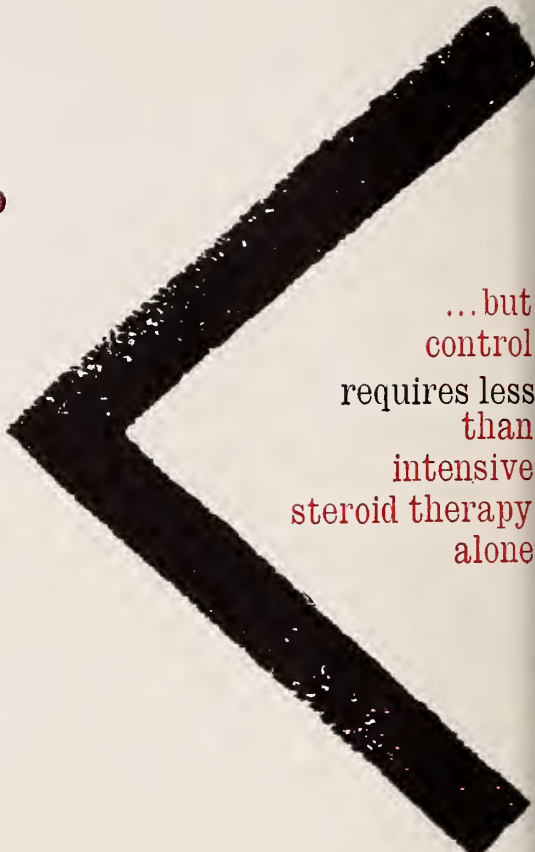
The Cleveland conference will be co-sponsored by societies in North and South Carolina, Tennessee, Alabama, Georgia, and Florida.

Medical societies from the District of Columbia, Virginia, West Virginia, Maryland, Delaware, and New Jersey will host the Baltimore meeting.



when the
rheumatic
disorder
is more
than salicylates
alone
can control...

MORE
HIGHLY INDIVIDUALIZED
THERAPY
FOR THE
RHEUMATIC
"IN-BETWEEN"



...but
control
requires less
than
intensive
steroid therapy
alone

Aristo

wider latitude in adjusting dosage

ARISTOGESIC is particularly effective for relief of chronic — but less severe — pain of rheumatic origin. ARISTOGESIC combines the anti-inflammatory effects of ARISTOCORT® Triamcinolone with the analgesic action of salicylamide, a highly potent salicylate. Dosage requirements for ARISTOGESIC are substantially lower than generally required for each agent alone. The exceptionally wide latitude of dosage adjustment with ARISTOGESIC permits well-tolerated therapy for long periods of time with fewer side effects.

Indications: Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis, and certain muscular strains.

Dosage: Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

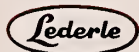
Precautions: All precautions and contraindications traditional to corticosteroid therapy should be observed. The amount of drug used should be carefully adjusted to the lowest dosage which will suppress symptoms. Discontinuance of therapy must be carried out gradually after patients have been on steroids for prolonged periods.

Each ARISTOGESIC Capsule contains:

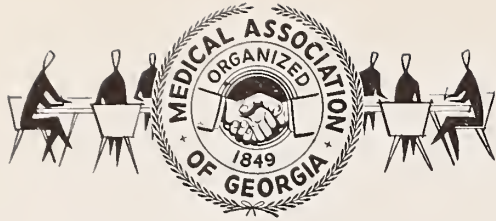
ARISTOCORT® Triamcinolone	0.5 mg.
Salicylamide	325 mg.
Dried Aluminum Hydroxide Gel	75 mg.
Ascorbic Acid	20 mg.

Supply: Bottles of 100 and 1,000.


gesic® Capsules
Steroid-Analgesic Compound LEDERLE



LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



the association

ANNOUNCEMENTS

Emory University Hospital announces the opening of a Psychiatric Unit which has been in operation since January 17, 1960. The Hospital wishes to announce that admissions are arranged through the psychiatrists at Emory University Hospital.

The American Board of Obstetrics and Gynecology announces that the next scheduled examinations (Part II), oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 11 through 16, 1960. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates. Candidates who participated in the Part I Examinations will be notified of their eligibility for the Part II Examinations as soon as possible.

The deadline date for the receipt of new and reopened applications for the 1961 examinations is August 1, 1960. Candidates are urged to submit their applications as soon as possible before that time.

For further information contact: Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

St. Joseph's Infirmary, Atlanta, announces the Basic Science programs to be held this year, which are open to all physicians, medical students, and members of allied sciences. They are as follows: "Clinical and Applied Neurophysiology," March 14-18; "Physiology of the Heart and Circulation," April 18-22; "Fluid and Electrolyte Balance," May 16-20, and "Trauma Symposium Care of the Injured Patient," June 6-10. There is no registration fee. For further information, call the office of the Director of Medical Education, JA. 5-4681, Ext. 324.

The New York University Post-Graduate Medical School offers the following course in Medicine: "Electrocardiography," a full-time, five-day course, Monday through Saturday (excluding Wednesday and Saturday afternoons), March 14-19, 1960.

While this course is suitable for physicians without previous electrocardiographic training, it has been found from experience that physicians with considerable electrocardiographic experience likewise derive benefit.

For application: Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York 16, N. Y.

DEATHS

WILEY MONROE FLANAGIN died suddenly November 30, 1959 at the age of 80 at his home in Waycross.

Dr. Flanagin received his degree in medicine from Emory University. He attended Reinhardt College and the Atlanta School of Medicine and began practice of medicine in New Lacey in 1912.

He came to Waycross in 1922 from Alma, and since that time he had taken an active role in medical, civic, and social circles of the community and South Georgia.

Dr. Flanagin held membership in the Ware County Medical Society, which he served as president, the Eighth District Medical Society, The Medical Association of Georgia, and the American Medical Association. He was a member of the First Baptist Church and a former Mason.

Survivors include his wife; one son Dr. Stewart Flanagin, Augusta; a daughter, Mrs. L. H. Grovenstein, Savannah; one sister, Miss Ida Flanagin, Canton; two brothers, G. W. Flanagin, Marietta and J. W. Flanagin, Canton.

WILLIAM EARL WOFFORD, SR. died at his home in Cartersville at the age of 71, December 13, 1959.

Dr. Wofford was a veteran of World War I, serving as Captain in the Medical Corps.

He was a member of the First Presbyterian Church and for many years served on the Board of Deacons and was also an Elder of the church. He is a former president of the Bartow County Medical Association, a member of the Medical Association of Georgia, and the American Medical Association. He was a former member of the Cartersville Lions Club.

Survivors include his son, William E. Wofford, Jr., Cartersville; a daughter, Mrs. Jimmy Morris, Vienna, Va.; one brother, A. G. Wofford, Nashville, Tenn.; and one sister, Mrs. Mary C. Hope, Austell.

SOCIETIES

At a recent meeting of the BLUE RIDGE MEDICAL SOCIETY the following officers were elected for 1960: Charles B. Watkins, Ellijay, president; R. A. Burns, Blue Ridge, vice-president, and Thomas J. Hicks, McCaysville, secretary.

At the December meeting of the CHEROKEE-PICKENS MEDICAL SOCIETY held at the Pinecrest Inn in Canton, John P. Heard, Decatur, presented a program on the Forand bill.

New officers of the DOUGHERTY COUNTY MEDICAL SOCIETY for 1960 are: D. D. Merren, president; O. Grey Rawls, vice-president, and R. D. Waller, secretary. Named to the society's governing board were: Frank K. Neill, H. M. McKemie, and J. Z. McDaniel.

A free public forum on polio was sponsored by the FULTON COUNTY MEDICAL SOCIETY and the Fulton-DeKalb chapter of the National Foundation recently.

Officers for 1960 were installed at the FULTON COUNTY MEDICAL SOCIETY'S annual banquet held at the Piedmont Driving Club recently. The following were elected to posts for which contests developed: Hugh Haily, senior member of the board of trustees; Conway Hunter, Jr., junior member of the board of trustees; Lester Rumble, Jr., judicial councilor, and August B. Turner, Tully T. Blalock, A. O. Linch, Shelley C. Davis, and J. Frank Walker, delegates from the society to the Medical Association of Georgia.

The following officers were elected for 1960 at the annual meeting of the GEORGIA MEDICAL SOCIETY: T. A. Peterson, president-elect; Oscar H. Lott, president; W. Lloyd Osteen, vice-president; W. Lawrence Salter, secretary, and W. W. Osborne, treasurer. Members of the society and their wives were guests at a Christmas party given by the Association of Medical Assistants.

The RICHMOND COUNTY MEDICAL SOCIETY recently elected the following officers for 1960: A. Jack Waters, president; John B. Bowen, president-elect; Preston Ellington, vice-president, and F. N. Harrison, secretary-treasurer. Dr. Waters and Dr. Harrison were named delegates to the Medical Association of Georgia for three years, with J. R. Fair and R. G. Ellison chosen as alternates. William A. Fuller was named a councilor to the Medical Association of Georgia, with Pomeroy Nichols, Jr. as vice-councilor.

For 1960, the TROUP COUNTY MEDICAL SOCIETY elected the following officers: R. S. O'Neal, president; W. M. Hendrix, vice-president, and J. T. Mitchell, secretary-treasurer. Hilt Hammett, Jr. was re-elected to represent the society at the Medical Association of Georgia's convention in Columbus May 1-4.

Vilda Shuman has been elected president of the WARE COUNTY MEDICAL SOCIETY for 1960. Other officers include: Neal F. Yeomans, president-elect; A. T. Adkins, secretary-treasurer, with W. L. Pomeroy and Leo Smith being re-elected as delegates to the Medical Association of Georgia.

The WALKER-CATOOSA-DADE MEDICAL SOCIETY recently elected the following officers for 1960: Warren Terrell, Rossville, president; Jerome Payne

Sims, Fort Oglethorpe, president-elect; LeRoy Sherrell, Rossville, secretary-treasurer; Fred Simonton, Chickamauga and Howard Derrick, Lafayette, delegates to the Medical Association of Georgia.

PERSONALS

First District

The new officers of the St. Joseph's Hospital staff in Savannah are: LAWRENCE S. BODZINER, president; IRVING VICTOR, vice-president; and J. P. EVANS, secretary.

Second District

TOM EDMUNDSON of Tifton recently demonstrated to the Tifton Rotarians how a patient under hypnosis can be instructed to feel no pain.

Third District

No news submitted.

Fourth District

No news submitted.

Fifth District

THOMAS F. SELLERS of Atlanta has recently been promoted from Assistant Professor of Medicine at Emory University to Chairman of Preventive Medicine and Community Health.

LOUIS S. RICCARDI of Atlanta has recently begun holding part time office hours in Roswell.

Sixth District

DAVIS S. REESE of Carrollton received the Silver Beaver Award at the 44th annual banquet of the Atlanta Area Council, Boy Scouts of America held at the Dinkler-Plaza Hotel recently.

Seventh District

No news submitted.

Eighth District

E. R. JENNINGS of Brunswick recently spoke to the St. Simons Island Rotary Club.

Ninth District

W. BRUCE SCHAEFER, Toccoa, has been notified by the State of Georgia Nuclear Advisory Commission that he has been appointed chairman of the committee on medicine. Dr. Schaefer, who was a member of the original commission, received his appointment to the new Georgia Nuclear Advisory Commission from Governor Ernest Vandiver several weeks ago. Also, Dr. Schaefer, who was chairman of the state committee that investigated the hospital at Milledgeville, spoke to the Elberton Rotary Club recently on the recent probe and subsequent findings at Milledgeville.

Tenth District

DANIEL B. SULLIVAN has announced the opening of his office in Augusta. He is a general surgeon whose practice is limited to neoplastic diseases.

H. G. BYRD, Athens, has recently retired from active practice.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE EXECUTIVE COMMITTEE OF the Council of the Medical Association of Georgia held a brief meeting on Sunday, December 13 at 10:10 A.M., Ashley Oaks Hotel Meeting Room.

Present were President Luther H. Wolff, Columbus; President-elect Milford B. Hatcher, Macon; Immediate Past President Lee Howard, Sr., Savannah; Secretary Chris J. McLoughlin, Atlanta; Chairman of Council J. G. McDaniel, Atlanta; and Finance Committee Chairman Virgil Williams, Griffin.

Mr. Krueger presented a letter from the Ware County Medical Society requesting any information as to whether or not entertaining a medical society constituted legitimate business expense and a deductible item for an M.D. of the Medical Society. After discussion it was suggested that Mr. Krueger write the Ware County Medical Society and suggest that expenses for meals be included in the County Society dues and this would clarify the matter. It was further suggested that if any additional information is desired they consult their local attorneys as this type advice does not properly come within the jurisdiction of MAG.

It was voted to hold the next meeting of the Executive Committee at 11:00 A.M., Sunday, January 10 in the MAG Headquarters Office.

There being no further business the meeting was adjourned.

COUNCIL MEETING

THE MEETING OF THE Medical Association of Georgia Council was called to order at 2:20 P.M. by Council Chairman J. G. McDaniel on December 12, 1959 at the Ashley Oaks Restaurant, Valdosta, Georgia.

Council members present included: Luther H. Wolff, Columbus, President; Milford B. Hatcher, Macon, President-elect; Lee Howard, Sr., Savannah, Immediate Past President; Corbett Thigpen, Augusta, First Vice President; W. P. Rhyne, Albany, Second Vice President; Chris J. McLoughlin, Atlanta, Secretary; Thomas W. Goodwin, Augusta, Speaker of the House; George R. Dillinger, Thomasville, Second District, Councilor; Virgil Williams, Griffin, Fourth District Councilor; J. G. McDaniel, Atlanta, Fifth District Councilor; George W. Alexander, Forsyth, Sixth District Councilor; Ralph W. Fowler, Marietta, Seventh District Councilor; F. G. Eldridge, Valdosta, Eighth District Councilor; C. R. Andrews, Canton, Ninth District Councilor; Vice Councilors present included T. A. Peterson, Savannah, First District; Willis P. Jordan, Columbus, Third District; James M. Hicks, Brunswick, Eight District and Paul T. Scoggins, Commerce, Ninth District, AMA-MAG Delegate Henry H. Tift, Macon was also present. MAG staff members present included Mr. Milton D. Krueger, Executive Secretary and Mr. John F. Kiser, Associate Executive Secretary. Also present was Mr. John Moore, Atlanta, MAG Counsel.

Mr. M. D. Krueger read the minutes of the Medical Association of Georgia Council meeting of October 10-11, 1959; the Executive Committee of Council meeting minutes of October 11, 1959 and November 15, 1959. On motion duly made and seconded, these minutes were approved as read.

Legislative Committee Report

Mr. John Kiser reported on the November 15, 1959 MAG Legislative Conference on the Forand bill held in Atlanta for County Medical Society Presidents and Secretaries. Mr. Kiser reported that the County Medical Societies were responding by holding local meetings of the societies. Mr. Kiser also discussed the state legislative program of the Legislative Committee and the Committee's proposed activity on national legislation. In discussion of this report, the progress of the Association in presenting a positive program on health care of the aging was emphasized.

AMA Dallas Clinical Meeting

Henry Tift, AMA-MAG Delegate, reported on the action of the House of Delegates of the American Medical Association meeting held December 1-4, 1959, Dallas, Texas. Dr. Tift stated the items under discussion concerned the following subjects: (1) Freedom of Choice of Physician; (2) Physician-Hospital Relations; (3) Scholarships for Medical Students; (4) Relative Value Scale Studies; and other miscellaneous actions considered by the House of Delegates of the AMA. Dr. Tift also reported that the MAG Resolution on the inclusion of a socio-economic course in Practice of Medicine for the medical schools over the nation was approved by the AMA House of Delegates.

Insurance Committee Report

Dr. Thomas Goodwin reported for Insurance and Economics Committee Chairman David R. Thomas. In behalf of Dr. Thomas, Dr. Goodwin requested the Council to furnish more data concerning coverage of MAG members during the conduct of MAG business. By general recommendation, it was requested that the Headquarters Office get data from the Florida State Medical Association, which has this type coverage, and forward this information to Insurance and Economics Committee Chairman David R. Thomas as a guide for his investigation of the matter.

Dr. Goodwin presented a progress report concerning coverage of the MAG membership at this time under the three MAG endorsed programs of the Life of Georgia Insurance Company.

Dr. Goodwin then asked Council whether or not the Insurance and Economics Committee should investigate further a retirement plan for MAG membership and by general recommendation the Council requested the Insurance and Economics Committee to investigate all types of retirement plans and report back to the Council as soon as possible on this matter.

Mr. Krueger brought up the question of the matter of coverage of the full-time employees in the MAG Headquarters Office, at their own expense, under the Group Contract between MAG and the Life of Georgia Insurance Company. By general agreement the Council asked that the Chairman of the Insurance and Economics Committee discuss this proposed coverage with officials of the Life of Georgia Insurance Company, and further they discuss the possibility of including physician's employees under said coverage. It was also recommended that partnership insurance on a group basis should be investigated by the Insurance and Economics Committee for further report to Council.

Dr. Goodwin then asked for clarification of the recent action of Executive Committee meeting on November 15 concerning certain questions in the Life of Georgia Insurance Program for MAG. Dr. Goodwin stated that Executive Committee had directed Dr. Thomas to write the membership a letter to clarify these questions. By general agreement, it was felt that the questions raised at the November 15 meeting by the Executive Committee had been answered by the Life of Georgia Insurance Company in an all member mailing which was sent to the membership a few days after the November 15 meeting.

Lectureship Committee Report

George Alexander, Chairman of the Lectureship Committee, reported that Dr. Murdock Euen had withdrawn his proposed MAG Annual Session Lectureship. Dr. Alexander stated that the Lectureship Committee had met December 10 and discussed the ground rules for lectureships which was previously approved by Council at their July 25-26, 1959 meeting. He also discussed the matter of his Committee contacting the Calhoun family so that they might be able to appoint a lectureship representative in connection with the Abner W. Calhoun Memorial Lectureship. Dr. Alexander then stated that as any suggestions for a speaker on a Lectureship Program would be presented directly to the Annual Session Chairman, and that as the ground rules had been approved by Council; he felt that the discharge of the Lectureship Committee would be in order. After some discussion concerning the applicability of the ground rules, it was moved (Dillinger-Hatcher) and voted that the Lectureship Committee should "rough draft" the wording of the Bylaws on the matter of ground rules for Lectureships and report with this rough draft at the next Council meeting.

Cultists Problem

Mr. John Moore, MAG Counsel discussed the problems in protecting the public from cultists' practice in the healing arts. Mr. Moore emphasized the State Medical Association should provide advice and a guide for county societies, but also that the county societies must take leading action in these matters.

Mr. Moore reported on certain areas in the state and Councilors discussed their areas of the state in regard to cultists problems.

Medicare Contract Renewal Option

Mr. M. D. Krueger, reporting for Mr. John Arndt, Medicare Administrator, presented the action of the Executive Committee of Council meeting November 15, 1959 at which time it was moved and voted that the Executive Committee of Council recommended to Council that the Association maintain its Medicare contract under the present system. After discussing this recommendation, on motion (Goodwin-Dillinger) it was voted to renew the present Medical Association of Georgia contract DA 49-007MD 812, Dependents Medical Care Act, PL 569, 84th Congress.

Headquarters Office Building Committee Report

Chris J. McLoughlin, Chairman of the Headquarters Office Building Committee, reported that the Gulf Life Insurance Company would move on January 2, 1959 and the building would be ready for occupancy on or after that date. He also stated that the purchase of the building would be closed by MAG attorneys on December 30, 1959. Dr. McLoughlin related progress on the Shaw-Walker Office Systems Survey of the Headquarters Office. He also reported that the possible encroachment on the Gulf Life property by the owner of the adjacent property was under discussion by the MAG Attorney and the owner of the adjacent lot. He then related that an offer for purchase of the frontage on Cypress Street (back end of MAG property) had been received. Dr. McLoughlin discussed the needs of office equipment and the condition of the building. He also asked for a Council recommendation on the sign for identification of the Medical Association of Georgia on the face front of the building. He then discussed certain insurance coverage for the building.

On motion (Dillinger-Hatcher) it was voted that the problem of a sign on the building identifying the Medical Association of Georgia be referred to the Building Committee with power to act. Also on motion duly made and seconded, it was voted that the offer for the purchase of the Cypress Street frontage property be rejected.

On motion duly made and seconded (Hatcher-Dillinger) it was unanimously voted as follows: Resolved, that the President and Secretary of the Medical Association of Georgia are authorized and directed to execute and attest respectively the note and security deed in the Gulf Life Insurance Company form approved by the MAG general counsel in connection with the closing of the purchase of the new Headquarters Office Building at 938 Peachtree Street, N.E., Atlanta, Georgia.

By general agreement, the recommendation of the Executive Committee recommending to Council the appropriation for some additional funds for the completion of the Shaw-Walker Office Systems Survey was discussed. The matter was referred to the action pursuant to the approval of the MAG 1960 Annual Budget; which if approved would cover this matter.

Finance Committee Report

Virgil Williams, Chairman of the Association Finance Committee presented the Annual monthly budget report and after discussion, on motion (Wolff-Dillinger) it was voted to approve and accept this Budget Report for information.

Dr. Williams then presented the proposed MAG 1960 budget as prepared by the Finance Committee. Each and every item in the budget was fully discussed and the following action was taken:

(1) On motion (Simpson-Dillinger) it was voted that the Council in approving a budget of \$500 for the Crawford W. Long Memorial Committee believes that this appropriation should represent the final financial responsibility of the Association.

(2) On motion duly made and seconded it was voted as recommended by the Finance Committee that all excess funds beyond the stipulated reserves be applied to the purchase of the new Headquarters Office and that \$10,000 be deducted from the Building Fund for the purchase of equipment. In clarifying this action, another motion (Wolff-Hatcher) was voted, that a minimum of \$120,000 be applied to the building payment and equipment purchase, and more if authorized by the Finance Committee.

(3) On motion (Dillinger-Thigpen) it was voted that the 1960 MAG Annual Budget as proposed and presented by the Finance Committee be approved as presented. This approved budget is presented herein:

PROPOSED MAG 1960 BUDGET

	Budget 1959 Budget	Income & Disbursements 10/30/59	Proposed Budget for 1960
INCOME			
Income from dues . . .	\$ 95,000.00	\$ 98,142.50	\$ 98,500.00
Journal Advt.	45,000.00	36,805.55	47,000.00
Fees Exhibitors	8,750.00	8,750.00	8,400.00
Interest & AMA	2,600.00	3,120.02	500.00
GP	2,520.00	2,100.00	2,820.00
	\$153,870.00	\$148,918.07	\$157,220.00
DISBURSEMENTS			
1. Salaries	\$ 27,910.00	\$ 23,149.93	\$ 28,780.00
Bonus	1,542.50	—	1,557.50
GP	2,520.00	2,100.00	2,820.00
	\$ 31,972.50	\$ 25,249.93	\$ 33,157.50
2. Fixed Allotments			
Pension Payments . . .	\$ 1,200.00	\$ 450.00	\$ 1,200.00
Honorarium	1,000.00	1,000.00	1,000.00
Atty. Retainer	1,200.00	1,200.00*	2,400.00
Special Atty. Exp. . . .	1,000.00	—	500.00
Annual Audit	500.00	509.34	500.00
Cont. F.C.M.S.	1,500.00	1,500.00	200.00
Insur. & Bonds Pers. .	1,000.00	879.75	1,250.00
Woman's Aux.	1,500.00	1,500.00	1,500.00
	\$ 8,900.00	\$ 7,039.09	\$ 8,550.00
3. Journal Publication			
Salaries	\$ 5,250.00	\$ 4,456.25	\$ 5,700.00
Bonus	575.00	—	662.50
Engraving & Cuts . . .	1,500.00	1,111.49	1,800.00
Editorial Asst.	200.00	100.00	250.00
Stationery	400.00	632.22	500.00
Postage	650.00	500.00	700.00
Clipping Service . . .	350.00	307.90	450.00
Add & Supplies	250.00	194.31	250.00
Copyright	50.00	48.00	50.00
Printing	35,000.00	30,911.14	38,000.00
Sales Tax	1,050.00	927.64	1,140.00
Sundry & Meetings . .	100.00	58.36	400.00
	\$ 45,375.00	\$ 39,247.31	\$ 49,902.50
4. Headquarters Expense			
Travel	\$ 4,000.00	\$ 1,220.94	\$ 4,000.00
AMA Travel,			
Del. Sec. Ex.	2,500.00	1,245.44	2,500.00
Meetings	750.00	450.95	750.00
Stat. Prtg. Supp. . . .	1,800.00	1,180.95	1,800.00
Postage	1,800.00	1,886.58	2,000.00
Tel. & Tel.	2,500.00	2,398.63	2,800.00
Depreciation &			
Replacement	1,100.00	—	1,200.00
Service Office			
Maintenance	500.00	426.05	750.00
Dues & Sub.	200.00	190.00	200.00
Janitor Serv. & Grat.	650.00	477.00	1,250.00
Payroll &			
Uncmp. Tax	1,000.00	928.02	1,000.00
Sundry	450.00	150.10	450.00
Building Maint.			5,000.00
Bldg. Depre. &			
Major Repairs			1,500.00
Interest on Mort. . . .			4,000.00
	\$ 17,250.00	\$ 10,554.66	\$ 29,200.00
5. Committee Expenses			
Council Committees			
1. Annual Session	\$ 10,681.00	\$ 9,868.11	\$ 11,000.00
2. Dist. Serv.			
Award	300.00	—	650.00
3. Headquarters			
Bldg.**	500.00	—	4,500.00
4. Health Care			
Aging		*	1,000.00
5. Med. School			
Courses	250.00	118.12	200.00
	\$ 11,781.00	\$ 9,986.23	\$ 17,350.00

the association CONTINUED

	1959	Income & Disbursements 10/30/59	Proposed Budget for 1960
Standing Committees			
6. Crawford W. Long . . .	\$ 1,500.00	\$ 1,500.00	\$ 500.00
7. History & Vit. St. . . .	300.00	—	300.00
8. Hospital Rel. . .	500.00	132.93	1,000.00
9. Indust. Health . .	300.00	207.82	300.00
10. Ins. & Econ. . .	600.00	186.21	600.00
11. Legislation . . .	2,400.00	2,361.16	2,810.00
12. Maternal Welfare . .	100.00	62.59	200.00
13. Med Defense . .	3,500.00	1,234.38	2,000.00
14. Med Education . .	250.00	183.65	150.00
15. Mental Health . .	250.00	160.91	250.00
16. Prof. Conduct . .	—	—	50.00
17. Public Service . .	1,000.00	1,116.72	1,800.00
18. Rural Health . . .	1,005.00	999.24	500.00
19. Scientific Awards . .	100.00	109.13	100.00
	\$ 11,980.00	\$ 8,254.74	\$ 10,560.00
Special Committees			
20. Health Column . .	2,525.00	2,508.48	2,650.00
21. Med. Civil Prep. . . .	50.00	—	50.00
22. Ministerial Liaison . .	450.00	—	250.00
23. School Child Health . .	—	—	1,850.00
24. V.F.W. Liaison . . .	—	—	50.00
	\$ 3,745.00	\$ 2,508.48	\$ 4,850.00
Related Committees			
25. AMA Del. Meeting . . .	\$ 500.00	\$ 27.00	\$ 1,000.00
26. Inter-Prof. C. . .	—	—	250.00
27. Physician-Lawyer . .	250.00	—	250.00
28. SAMA	300.00	118.71	500.00
29. SMEB	100.00	50.00	100.00
	\$ 1,150.00	\$ 195.71	\$ 2,100.00
Building		\$ 10,000.00	
Equipment	\$ 750.00	750.00*	
Total Disbursements . .	\$132,903.50	\$113,786.15	\$155,670.00
Contingent	5,000.00		1,550.00
Expenses for Retainer . .	—	181.74	—
Florida Medical Assn. . .	—	500.00	—
National Conference on Physicians & School . .	—	154.31	—
Attorney Retainer . . .	—	1,200.00	
M'ville Study Com. . . .		4,344.41	
Health Care of Aging . .		1,000.00	
Equipment		1,400.00	
		\$ 8,780.46	
Reserve Fund	\$ 15,966.50		
Bank Balance		\$ 47,087.82	
Savings & Building . . .		\$ 80,000.00	
Bonds (Maturity 1960-1-2)		\$ 27,312.00	

*Additional expenses charged to Contingent
 **(Moving and renovation)

SAMA Annual Meeting Expresses

Luther H. Wolff, President, presented a communication of December 8 from Mr. Glenn Bailey, President, Student American Medical Association Chapter, Medical College of Georgia. This

communication recommended an increase in the MAG allocation for the expenses of representatives of the Student American Medical Association at their annual meeting from the \$300 appropriation by MAG to \$500. It was further recommended that both schools be so notified and if either school does not use one-half of this sum as divided between the two schools, that the other school be allowed to take advantage of this by using the total sum of \$500, if necessary. It was emphasized that this money is used only to cover the expenses of SAMA delegates. Dr. Corbett Thigpen and Dr. Henry Tift spoke in favor of this request and on motion (Dillinger-Wolff) it was voted to write a letter to both medical schools stating that the Association will raise it's appropriation from \$300 to \$500 and that one-half of this sum is made available to each school, and if the school does not apply for this fund 60 days in advance of such an annual meeting that the balance of the sum be made available to the other school if requested.

On motion duly made and seconded it was voted to amend the previously approved MAG 1960 annual budget to increase the appropriation for SAMA from \$300 to \$500.

Blood Test Act

Virgil Williams presented a Board of Health request to have the Auxiliary to the Medical Association of Georgia aid and assist in providing information concerning the proposed repeal of the present blood test act in Georgia. On motion (Dillinger-Alexander) it was voted to refer this matter to the Legislative Committee and that the Legislative Committee with the Executive Committee be empowered to act on this matter, as they see fit.

Council Chairman McDaniel then recessed the Council meeting at 4:20 P.M.

RECONVENED COUNCIL MEETING, DECEMBER 13, 1959

Chairman McDaniel called to order the reconvened meeting of the Council of the Medical Association of Georgia at 8:05 A.M., December 13, 1959 at the Ashley Oaks Restaurant, Valdosta, Georgia.

Members of Council and guests present included all members attending the recessed meeting of December 12, 1959 with the exception of Corbett Thigpen, Augusta, First Vice President and T. A. Peterson, Savannah, First District Vice Councilor.

Boy Scout Physical Examination

Virgil Williams stated that a physical examination prior to and on arrival at boy scouts camps was being required by the Boy Scouts of America. Mr. Krueger reviewed the Rural Health Committee action on this same matter and the design and acceptance of a standard physical examination. In general discussion it was emphasized that there was no need for the second physical on arrival at camp and on motion (Williams-Fowler) it was voted to write the Boy Scouts of America National Headquarters requesting that the camp physical be eliminated and that one physical examination 15 days prior to the arrival at camp is sufficient. The motion further stated that this is the standard used in other camps and schools and that this action should also be sent to the Headquarters and Districts in the State of Georgia of the Boy Scouts of America.

Hospital-Medical Council Report

Dr. Hatcher reviewed the background of the Georgia Hospital-Medical Council and explained the accreditation program for smaller hospitals in Georgia. Mr. Krueger explained the inspection policies and described the recent presentation of a certificate to the Villa Rica Hospital, which was the first to be awarded in the state.

Following discussion, it was voted to send a letter from MAG Council to the Hospital-Medical Council commending them on their good work.

Report On AMA Medical Disciplinary Meeting

Mr. Kiser presented a brief report on a recent meeting of the AMA Disciplinary Committee held in Atlanta on November 16-17, 1959. Mr. Kiser pointed out that six other southern states were represented at this meeting as well as the Medical Association of Georgia and the Georgia Board of Medical Examiners. General discussion followed during which time it was pointed out that most other Southern states had much closer liaison with their State Board of Medical Examiners than is maintained

in Georgia. It was pointed out that Dr. Scoggins, 9th District Vice Councilor, was recently elected President-Elect of the Board and that this would help in increasing liaison with the Board of Medical Examiners in the future.

Headquarters Office Report

Mr. Krueger outlined in brief the proposed Office Systems Survey of the office to be conducted by the Shaw-Walker Company. In addition, he pointed out certain recent personnel changes in the office and proposed plans in regard to personnel in the future. He presented in detail the activities of the staff in connection with the Forand bill campaign. Mr. Krueger also outlined the activities now being conducted in connection with preparing the Annual Session program.

Memento for Fulton County Medical Society

Dr. McDaniel suggested that it might be appropriate to present Fulton County Medical Society with a suitable memento in recognition for the many years which MAG had occupied offices in the Academy of Medicine Building. After discussion it was voted (Wolff-Hatcher) that the Secretary and Chairman obtain some suitable memento for the Fulton County Medical Society, with funds up to \$200 as budgeted, and any additional funds necessary coming from the Contingent Fund.

On motion (Hatcher-Dillinger) it was voted that a suitable resolution be drafted and sent to the Fulton County Medical Society in appreciation for their fine cooperation over the years.

Journal Report

Mr. Krueger presented a report for Dr. Woody concerning a recent meeting of the State Journal Editors in Chicago. Mr. Krueger stated that Dr. Woody felt that the meeting was worthwhile and valuable material was obtained at this meeting for use by MAG *Journal* Staff. In addition, Mr. Krueger pointed out that the *Journal* had won an award as the outstanding *Journal* as regards typography.

On motion (Alexander-Scoggins) it was voted that the Council go on record as commending Dr. Woody and his staff for their fine work on the *Journal*.

Dr. Tift brought up the matter of sending the MAG *Journal* to all AMA Delegates and it was suggested that the feasibility of this matter be investigated.

Advisory Committee On Mental Institutions

Dr. Wolff presented a report of the Advisory Committee on Mental Institutions. Dr. Wolff stated that the Advisory Committee had been very diligent in its work having met every month since it was appointed in July.

Unfinished Business

(1) Dr. McDaniel reported on the emergency-call problem that had been previously discussed. He stated that Dr. W. G. Elliott had investigated this problem and suggested that a letter from Council be sent to Dr. Elliott thanking him for his work in this matter.

(2) Dr. Tift presented general information concerning the Annual Session to be held May 1-4, 1960 in Columbus. Dr. Tift urged all Councilors and Vice-Councilors to urge their colleagues to attend this Annual Session.

(3) Dr. Wolff reported that Gov. Ernest Vandiver will address the Association at the Annual Session on Sunday night,

May 1 following the meeting of the House of Delegates at a special session to be held in the auditorium.

(4) Dr. Tift reported that a problem in Macon concerning an optometrist, which had been brought up to Council earlier in 1959, had been solved.

(5) Mr. Krueger reported on action of the MAG House of Delegates and stated that a District Committee on Government Medical Care had been appointed by the District Society Presidents.

(6) Mr. Krueger presented a rough draft of a letter to be sent to Provident Life and Accident Insurance Company 60 days prior to the expiration of MAG Group Contracts with Provident. This letter was referred to Executive Committee.

(7) Dr. McLoughlin presented information on certain old MAG *Journals* which had been obtained from a deceased Brunswick physician's library.

(8) Dr. Howard reported on recent problems in connection with the corporate practice of medicine in Savannah and other communities. He stated that a committee of Georgia Medical Society had been appointed to work on this problem in connection with pathologists, anesthesiologists and radiologists. Dr. Howard stated that he had had assistance from the AMA and other sources.

New Business

It was voted (Hatcher-Alexander) that Council go on record as thanking Dr. and Mrs. F. G. Eldridge for their outstanding hospitality and the entertainment held at the Ocean Pond Club in Valdosta on Saturday, December 12. This vote was unanimous and Dr. Eldridge was given a rising vote of thanks.

Dr. Dillinger suggested that an appropriate message from Council be sent to C. Raymond Arp of Atlanta, MAG Treasurer, who has recently been hospitalized for illness.

Mr. Kiser presented a report of MAG Mental Health Committee Chairman Van de Wetering concerning a national meeting of Mental Health Chairmen held in Chicago in November. It was suggested that this fine report be published in the *Journal of the MAG*.

Mr. Kiser reported on certain problems in connection with the Wayne County Memorial Hospital in Jesup, Georgia. This matter was received for information.

Dr. Scoggins and others discussed the recent revocation of a physician's license by the State Board of Medical Examiners for information.

Dr. McLoughlin suggested that an appropriate present be purchased for a member of MAG Staff who was recently engaged to be married. This was so voted on motion duly made and seconded.

Dr. Scoggins asked whether or not Council approved of a Public Health Nurse performing tetanus toxoid injections in this County. On motion duly made and seconded, it was voted to disapprove this type of procedure.

Dr. Simpson suggested that all physicians bring their legislators to the annual session to hear Gov. Vandiver when he addresses the MAG Annual Session on Sunday night, May 1, 1960 in Columbus at the Auditorium.

It was decided that the March meeting of the Council would be held in Atlanta in the new Headquarters Office Building at 938 Peachtree Street, N.E., Atlanta.

It was suggested further that the Chairman of Council and the Secretary arrange an appropriate reception for the official opening of the new Headquarters Office Building.

There being no further business the meeting was adjourned at 10:10 A.M., Sunday, December 13.

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MAY 1-4, 1960

These are the dates for the

ANNUAL SESSION

of the

**MEDICAL ASSOCIATION
OF GEORGIA**

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COLUMBUS, GEORGIA

at the

MUNICIPAL AUDITORIUM

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EARLY GRAFTING OF THE BURN PATIENT

*One of the more important and most neglected facets of burn treatment
is early closure of the burn wound.*

MOST PATIENTS SURVIVE the initial insult but extensively burned patients frequently succumb to septicemia and malnutrition. These complications along with contractures are directly attributable to the open burn wound. Prevention of serious complications and early recovery depend upon an aggressive approach to early cover.

It is the purpose of this paper to summarize techniques in management of the burn wound that have evolved over an eight-year period in the treatment of 1,100 hospitalized burn patients.

Make a Timetable

The surgeon should formulate a timetable for the application of grafts. It is expected that most burn patients can be completely covered by the end of three months unless homografts have been required as a lifesaving measure. The first grafting procedure should be carried out on the 14th to the 30th day. In small wounds it may be possible to have the area ready for grafting at the end of two weeks. Larger wounds may require more time, but every patient should be managed in such a way that skin is applied by the 30th day. To wait longer for application of skin is neglecting the burn wound and may lead to serious complications.

The timetable also includes the second, third and further grafting procedures. One should achieve skin cover as rapidly as possible. After the recipient site is ready for grafting some skin should be applied whenever the patient is put to sleep for a dressing change. Only by making a firm timetable is it possi-

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ble to have an aggressive approach to rapid cover for the burn wound. Too frequently, one waits to graft until the patient is in better condition or until the recipient site has improved in appearance. In general, the patient does not improve appreciably until skin cover is applied to the wound. Skin placed on the burned surface early takes better than skin applied two or three months postburn.

Preparation of the Recipient Site

Before the recipient site can be prepared the eschar must be removed. This may be accomplished by surgical excision, wet soaks or repeated change of dry dressings. The most commonly accepted method is the use of wet saline packs. The wet dressings keep the eschar soft and when they are changed every four hours, loose eschars are removed. Warm moist packs are also helpful in the treatment of cellulitis about the wound.

Intensive investigation has been carried out on the use of various enzymatic debriding agents. None of the enzymes presently available has any practical value in extensively burned patients. They are quite expensive and do not remove the eschar any faster than saline soaks. In small wounds these agents may be of some value.

The objective in preparing the recipient site for grafting is to obtain a wound surface on which an optimum graft take may be expected. It is impossible to sterilize a granulating area and this is really

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unnecessary for a good graft take. The amount of purulent material on the wound has some influence on the graft take because large amounts of drainage will pocket beneath the grafts. Group A beta hemolytic streptococci have a deleterious effect on graft takes; therefore, it is essential that the recipient site be made as clean as possible but not necessarily sterilized. *Pseudomonas aeruginosa* contamination is common in burns but disappears as soon as a skin graft is applied.

Frequent changes of dry dressings, usually every other day, is a good method of preparation in most instances. Cultures of the wound must be taken to make sure that the beta hemolytic streptococcus is not present.

In wounds where there is an excessive amount of drainage and some nonviable tissue, the application of wet dressings changed three or four times a day is the preferable technique. This method affords good drainage and decreases the bacterial inoculum.

In some instances it may be necessary to apply local antibiotic ointments or antibiotics in the form of continuous moist packs. Local antibiotics are quite expensive and are rarely indicated. They are of particular value when there is a heavy bacterial population or when beta hemolytic streptococci are present.¹ When local antibiotics are used for the preparation of recipient sites they should be applied one day and grafting should be carried out two days later. Their effectiveness lasts only two days.

Occasionally, when grafting has been delayed, soft, pale, heavy granulation tissue may be present. Skin does not take well on such tissue. The granulations must be shaved down to the base and a dressing applied for two days. If grafts are applied immediately after scraping the granulations, hematomas may form beneath the grafts and cause a poor take. Sometimes when there is a considerable amount

of fibrous tissue beneath old granulations, it is advisable to excise the entire area down to normal tissue. A dressing is then applied and grafting carried out a few days later.

Selection of Donor Sites

The most accessible area from which to obtain skin is the anterior aspect of the thigh; however, the donor sites should be planned according to the place of application and the type of skin required. In many instances it is desirable to expose donor sites rather than apply dressings. When donor sites are to be exposed the selection of areas must be planned according to the position of the patient. Occasionally, the type of dermatome to be used determines the site of the graft. It is desirable to select the donor site and use the type of dermatome that will provide the most suitable skin.²

In extensive burns, every donor area available must be used in an attempt to achieve early skin cover. The popliteal area, the groin and the antecubital areas should be avoided. Sometimes it is necessary to take skin from the dorsum of the foot or the scalp in patients who have extensive burns. Under such circumstances small postage stamp strips of skin may be taken by means of the electric dermatome. In extensively burned patients an overall plan of donor sites should be made before the first grafting procedure is attempted.

Removal of Skin for Grafts

Skin grafts for burns have as their primary purpose rapid coverage. The split-thickness graft is preferred. Usually it is cut between .010 and .015 inches in thickness. The thinner the graft the better the take and the thicker the graft the better the cosmetic result. In extensive burns a very thin layer of skin (.010 inch) must be taken in order that the donor area may be used again within a short time for a second crop. In certain areas of function,

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such as the hand and around joints, a thicker graft (.015 inch) should be applied.

The type of instrument to be used varies with the experience of the operator.³ One important fact is that the blade must be sharp. Irrespective of the skill of the surgeon or the type of instrument used, a good skin graft cannot be removed with a dull blade.

The Brown electric dermatome is one of the greatest advances in the management of burns. It cuts a strip of skin three inches in width. Little experience is required for the successful removal of large amounts of skin with this instrument. Its only real disadvantage is that a flat firm surface must be available. On uneven surfaces, a Pitkin's syringe may be used to inject saline in the subcutaneous tissue and provide a smooth surface. This technique is of particular value on the foot, over the rib cage, on the arms and the lower leg. Before the skin is removed the area must be lubricated lightly with mineral oil. It is important that an assistant pick up the skin with forceps so that the surgeon can observe the thickness of skin and therefore the depth of the cut.

The Padgett and the Reese dermatomes are drum type instruments and are particularly useful for obtaining grafts from uneven surfaces. A wider piece of skin can be obtained with the drum type dermatomes than with the electric dermatomes. The depth of cut is usually more accurate with the drum type dermatome and the edges are smoother. Better skin for coverage of critical areas, particularly the hands, the face and around joints, is available with a drum type dermatome. Many grafting procedures require both the electric and the drum type dermatomes.

Application of Grafts

Application of skin grafts may be carried out by any one of three methods:

- (a) lay-on method
- (b) suture method
- (c) postage stamp method.

The best method for applying split-thickness grafts to large flat surfaces is the lay-on method. It is rapid and effective. It diminishes the time of anesthesia for the patient and is usually most successful. The skin is placed in such a way that the sheets are in close apposition. Grafts are held in position by applying a large, firm, bulky dressing. It is difficult to use this method on some irregular surfaces because the skin may wrinkle and slip.

The suture method should be used over irregular surfaces and points of motion such as the chin, neck, feet, hands, around the knees and elbows. Very

fine 0000 interrupted silk sutures may be used on a sharp cutting needle. If there is any fear that the grafts will slip, they should be sutured in place. It is often advisable to use the lay-on method for part of the grafts and the suture method for other grafts during the same procedure.

It is best to cover areas with large sheets of skin because a better final result is obtained with less scarring. In some instances it may be necessary to use postage stamp grafts. They are cut about 1 x 2 inches in size and placed in brick layer fashion not further than one inch apart. Postage stamp grafts should be used when the recipient site is so extensive that only limited amounts of skin are available for grafting. If there is a large amount of purulent material on the wound, postage stamp grafts allow drainage between the areas and is the preferred method. These grafts provide very adequate coverage on large flat surfaces. Sometimes when skin is in short supply, it is necessary to cover part of the area by a lay-on method and large flat surfaces by the postage stamp method.

Small perforations are necessary in grafts occasionally because serum may collect beneath the graft and prevent a good take. When large sheets of skin are sutured in place, it is advisable to make small perforations in the graft if it is over an uneven surface. Routine perforation of grafts, however, is unnecessary because frequently the flat surface on which the graft is placed leaves no area for the collection of serum. Perforations delay healing and should not be made unless necessary for drainage.

One of the most important factors in the grafting procedure is the application of a good dressing. This procedure must be carried out with great care. The dressing should be firm, bulky, and capable of producing even compression. It is important that the anesthesiologist keep the patient well asleep and immobilized during the application of the dressing. Should the patient move during this critical period the grafts would slip and a poor take would result.

The skin graft may be covered immediately with lightly impregnated petrolatum gauze, carbowax gauze or *Adaptic*.^{*} Over this should be placed a large amount of fluffed gauze to make the dressing bulky, absorptive, and permit even compression over the grafts. The dressing should be large enough to serve as a splint. If it does not completely immobilize the area, a plaster splint should be incorporated into the dressing. Motion is one of the most important factors in the failure of a graft take. An elastic bandage placed over the outside with great care to provide firm compression completes the dressing.

^{*}*Johnson & Johnson, New Brunswick, New Jersey.*

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Aftercare of Grafts

Infection, motion, and poor condition of the recipient site are the usual causes for poor graft take. Inadequate fixation and undue voluntary movement of the grafted area may displace grafts in the early postoperative period. Dressings should be changed between the third and sixth day, usually on the fifth day. If the surface on which the graft is placed is in poor condition, the graft should be inspected on the third day. At the first dressing change, great care must be exercised to prevent pulling away grafts that are not firmly fixed. When graft and gauze are adherent, irrigation with saline by means of a bulb syringe tends to loosen the gauze and thus prevent grafts from being torn from their base.

After the initial dressing change, other changes may be carried out at two to five day intervals. If some areas have not taken, additional postage stamp grafts may be applied to fill in the open areas. When all the unhealed areas are two centimeters or less in diameter, the affected part may be put in water to stimulate motion and allowed to remain free of dressings. The Hubbard tank is an excellent method of rehabilitation of the patient's activity and keeping the grafted areas clean. Early motion and early ambulation are most desirable.

Care of Donor Sites

For many years the accepted method of management of donor sites has been the application of an occlusive dressing. Various preparations have been suggested for local application. In most instances the occlusive dressing method has given good results. As long as a wound is kept free from infection the remaining epithelial islets regenerate and healing occurs. Epithelization is delayed by motion beneath the dressing. Mechanical trauma and infection are usually the chief deterrents to proper healing. Because infection occurs so often beneath dressings in burns the exposure method has been used rather widely. Exceptionally good results have been obtained particularly in warm climates. Exposure of donor sites has been one of the great advances in burn care because it has practically eliminated con-

version of donor sites to granulating areas.⁴ It is the preferred method of management for donor sites in burns.

The technique of exposing donor sites is to cover the area with fine mesh gauze as soon as the skin is excised. A warm, moist gauze pad is then applied to achieve hemostasis. It is important that good hemostasis be accomplished because when blood collects beneath the fine mesh gauze wound healing may be delayed.

The area of the donor site is permitted to remain exposed to the air. A firm coagulum soon forms from the blood that is caught in the interlacing fibers of the gauze. This coagulum dries within 24 hours and, when hardened, serves as a protective covering for the wound. The patient usually complains of moderate pain until the coagulum dries but this discomfort may be controlled by minimal doses of a narcotic. After the coagulum hardens the patient has no further discomfort from the donor area. Epithelization proceeds beneath the coagulum. As the healing progresses the protective covering loosens at the edges and falls off after about two weeks.

Sometimes when donor sites are exposed it is particularly desirable to put a temporary dressing over the fine mesh gauze for 24 or 48 hours. This prohibits scratching and contamination of the area and occasionally prevents pain from the exposed donor area. The disadvantage in using this method of exposure is that considerable pain occurs when a temporary dressing is removed at the end of 24 hours. In children, it is usually advisable to apply this temporary cover because it prevents interference with the fine mesh gauze that has been placed over the area.

University of Mississippi School of Medicine

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FIFTY YEAR CLUB

DR. J. H. McCURRY, of Cash, Ark. advises that he has the approval of the American Medical Association to organize a Fifty Year Club within the AMA. Dr. McCurry is anxious to hear from physicians who have been in practice 50 years or more who desire to be-

come members of this club, giving their name and a complete address.

The first meeting is to be held in Washington, D. C. at the Clinical meeting November 29 to December 2, 1960.

ATHEROGENESIS AND ITS RELATION TO DIABETES

*This is a review of selected work which is representative of the investigations
being carried on in this field at the present time.*

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Virginia S. Whitner, M.S.; and J. Gordon Barrow, M.D., *Atlanta*

ATHEROSCLEROSIS HAS BEEN considered an inevitable, progressive result of aging and wear, but on occasion it has been found in certain individuals to be either essentially absent or a highly damaging pathologic process. The great variability in the severity of atherosclerosis observed among individuals and the absence of this lesion in certain individuals have led to the idea that atherosclerosis is a definite disease process.

Atherosclerosis must be of multiphasic origin. It has become apparent that many factors and associations participate in the development of atherosclerosis. Any explanation of the atherosclerotic process must account for the higher incidence of atherosclerosis in certain conditions and diseases.

A reconsideration of the effect of diabetes on atherogenesis appears appropriate in light of recent advances in lipid chemistry as well as in other possible factors influencing atherosclerosis. This presentation includes, therefore, first a review of current theories of atherogenesis, next the effect of diabetes on atherogenesis, and finally the influence of therapy and controlled environmental factors on atherogenesis in diabetes.

The Atherosclerotic Process

The host susceptibility and reactions leading to atherosclerosis can be grouped as follows: (1) tissue structural, coagulation, and metabolic reac-

tions; (2) blood biochemical and clotting associations; (3) host constitutional reactions; and (4) environmental effects on the host.

Tissue Structural, Coagulation, and Metabolic Reactions

Structural Changes: Development of atherosclerosis becomes quite likely at a site of injury to the vessel wall, no matter what is the cause, since structural damage increases the clotting tendency and alters the tissue metabolism to permit deposition of lipids. Lipid streaks have been identified as early atherosclerotic lesions.⁶⁹ Recently early focal intimal lesions have been described as three types: (1) gelatinous elevations; (2) fatty dots and streaks, and (3) fibrin thrombi.⁴⁷ The frequency of each type of early lesion was 64 per cent gelatinous elevations, 27 per cent fatty streaks, and nine per cent fibrin thrombi. The gelatinous elevations consist of edematous swelling of intima and swollen ground substance. The fatty dots and streaks are comprised of accumulation of foam cells and have surprisingly little connective tissue or reactive fibrosis. The fibrin thrombi, some grossly visible and others invisible, are mural thrombi composed of platelets and fibrin. These three types of lesions could be secondary to injury to the vessel wall and could represent the initial step toward atherogenesis.

A demonstrable change in early atherosclerotic lesions is alteration in the histochemical staining of arterial mucopolysaccharides.¹⁹ Increased content of carbohydrate-sulphuric acid esters appears associated with deposition of cholesterol in the vascular wall. The process of ionic exchange has been sug-

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ATHEROGENESIS / Cooper

gested as the mechanism which circulating depolymerized chondroitin sulphuric acid and cations utilize to participate in deposition and fixation of lipids.⁹ Association of alteration of connective tissue ground substance with excessive deposition of cholesterol apparently has been confirmed by findings in hypercholesterolemia of more intense histochemical mucopolysaccharide stains of atheromatous lesions⁶³ and of a significant rise of sulphated mucopolysaccharides of the aorta.³⁹

Changes in composition of the atherosclerotic blood vessel wall apparently include increased lipid-binding capacity of protein (up to seven times the normal quantity of lipids) and alterations in the ground substance.³⁵ Proteins extracted from normal intimas revealed three electrophoretic fractions while only one was found in atherosclerotic intimas.

The possible role of cellular mechanisms in cholesterol and calcium deposition is emphasized in a report of a patient without hypercholesterolemia, but with Schuller-Christian disease, who showed repeated appearances of fresh lesions of arteriosclerosis over a period of 27 years.⁵²

Vessel Surface Clotting Factors: Certain phases of atherogenesis can be initiated by fibrin deposition on the inner wall of the arteries, particularly at a site of injury.¹⁷ Thromboplastin released from injured tissues reacts with plasma factors almost instantaneously to form a clot on the inner surface of vessel. In this case, therefore, clotting originates from the vessel wall rather than from changes in blood coagulation factors. The deposited fibrin becomes covered with a layer of intimal cells incorporating not only the fibrin but also platelets, erythrocytes, and leukocytes into the vessel wall. Following this, hyalinization, intimal proliferation, and fatty changes appear near the intimal-covered clot. It has been concluded that the common white plaque observed in arteriosclerosis arises from organization of thrombi.²⁹

Blood Biochemical and Clotting Associations

Lipids: Cholesterol, phospholipids, neutral fats, fatty acids, and lipotropic factors are being subjected to continuing investigations, particularly as they relate to atherogenesis. Not only are the types of lipids important, but their concentration and physical structure influence atherogenesis.

Cholesterol is suspected of playing a role in atherogenesis because atheromata contain cholesterol, patients with hypercholesterolemia show a high incidence of severe atherosclerosis, and dietary cholesterol can experimentally produce atherosclerosis in a susceptible animal or fowl. The serum

cholesterol concentration in the human is not affected appreciably by ingested cholesterol, but is strongly influenced by the amount and kind of fat in the diet.³⁸

Cholesterol deposition in the arterial tissues has been explained by four different mechanisms: (1) hepatic Kupffer cells, after phagocytosis of chylomicra, subsequently detach and are forced into the arterial walls by the hydrostatic pressure of the blood stream;⁴³ (2) the arterial endothelium proliferates and incorporates layers of foamy cells resulting from phagocytosis of cholesterol in macromolecules;³¹ (3) the vasa vasorum, plentiful at vascular branchings and pathological sites of vessels, permit accumulation of chylomicra and subsequent deposition of cholesterol when the fairly easily soluble lipids leave cholesterol behind as the chylomicra disintegrate;⁷⁷ and (4) cholesterol protein-lipid complexes are forced from the blood stream into the vessel walls at sites of increased centrifugal arterial pressure. Deposition also occurs in areas of injury to vessel wall. In case of severe vascular damage or excessive deposited cholesterol, the macrophages deteriorate, redepositing cholesterol.²⁷ Clinically, groups of individuals with myocardial infarction or hypertension have been found to possess higher cholesterol levels than those of "normal" groups, yet in studies on sudden death, no correlation has been noted between level of serum cholesterol and extent of atherosclerosis.²⁷

Essential hypercholesterolemia is associated with a high potentiality for atherosclerosis but whether it becomes an actuality in an individual depends on environmental circumstances. This defect is controlled by a dominant gene with incomplete penetrance.² Arbitrarily, values above 280 mg. per cent are usually considered in the hypercholesterolemia range. It is believed that the mechanisms involving cholesterol and leading to atherosclerosis in essential hypercholesterolemia are accelerated merely by the increased concentration of reactants.

Phospholipids are present in atheromatous plaques and can be synthesized in arterial walls.⁷⁸ They show concomitant variations with elevations or depressions of cholesterol levels.⁶¹ Their variations with age and sex is similar to that of cholesterol, but of lesser magnitude, and their serum level in healthy people is determined apparently by a genetic factor. One of the main functions of serum phospholipid is to keep serum cholesterol in solution by stabilizing it.⁷ Evidence suggests that a persistently high cholesterol with a low phospholipid (C/P ratio) results in increased atherosclerosis while the normal or low cholesterol with a high phospholipid correlates with a low degree of atherosclerosis. This can be inter-

puted to mean that a low C/P ratio of blood tends to inhibit atherogenesis.

Neutral fat elevation (hyperlipemia) has also been associated with premature development of atherosclerosis.⁴¹ It is the neutral fats (triglycerides) that cause lactescence of blood serum⁷² and gross clouding occurs at levels near 1500 mg. per cent. Lipemia apparently acts in two ways: (1) to aid cholesterol in atherogenesis and (2) to aggravate arterial insufficiency, even to extent of precipitating anginal attacks.⁴¹ In six patients with hyperlipemia and clinical atherosclerosis, manifestations of cardiac and peripheral ischemia can be roughly correlated with rise and fall of serum triglyceride level. This suggests that oxygenation of arterial blood or oxygen diffusion to the tissues is adversely affected in diseased vessels by hyperlipemia. This is in contrast to the traditional explanation of post-prandial angina.

Fatty acids have received considerable attention recently because they are involved in the metabolism of cholesterol^{33,6} and their degree of saturation influences the serum cholesterol,^{38,6} Isocaloric substitution of different fats in the diet indicates that highly saturated fats like coconut oil are associated with higher levels of serum cholesterol and phospholipids while unsaturated fats like corn oil in the diet decrease serum lipid levels.^{5,6} Certain unsaturated dietary fats lower the serum phospholipid to a lesser extent than cholesterol, possibly providing a beneficial effect by decreasing the cholesterol-phospholipid ratio.⁶⁴ It has been suggested that two grams of unsaturated linoleic acid is needed to counter the effect on cholesterol of one gram of saturated stearic fatty acids but lower in unsaturation, indicates that the degree of unsaturation exerts considerable influence on the level of cholesterol, phospholipid, and triglycerides.⁶ Further, differences in serum triglyceride fatty acids suggest a possible metabolic difference between patients with hyperlipemia and those with hypercholesterolemia.⁶

Lipotropic substances like choline, methionine, and inositol have questionable influence on atherogenesis. Fatty deposits have been observed in the endothelium of the aorta, carotid, and coronary arteries of rats on a choline-free diet.²⁸ Studies on patients with angina showed no influence of choline and inositol on angina and on levels of serum cholesterol and phospholipid.³² Deficiency of choline is unlikely as a cause of atherosclerosis since adequate amounts exist in a wide variety of vegetable and animal foods.²⁷

The physical structure of chylomicra and other lipid complexes is important for dispersion stability

and any changes from a stable configuration tend to flocculate the colloidal lipid dispersion. The particulate lipid-protein complex apparently positions the protein moiety at the center surrounded concentrically by a layer of cholesterol, then outside this with a layer of phospholipids, and outermost with a shell of neutral fats. The protein and phospholipid are the stabilizing components which bind variable amounts of lipids. Two or three types of protein are available for incorporation in chylomicra and they appear to be necessary for stabilization and satisfactory transport of chylomicra as well as activation of triglycerides for hydrolysis by enzymes.⁶⁰

Lipids separated by the ultracentrifuge have been tested as possible indicators of atherosclerosis.¹⁴ Lipoproteins have been classified by flotation constants, beta cholesterol density fractionation, and sedimentation constants. Evidence suggesting that measurement of lipoproteins with flotation constants between 0-400 is able to discriminate between "normal" and coronary disease groups is controversial.^{14,62} Determination of beta cholesterol in the top fraction of serum isolated after overnight ultracentrifugation in a medium density of 1.063 reflects variations in serum lipid content.³⁰ Sedimentation studies have detected an alpha-1 lipoprotein of sedimentation constant near five and a beta-1 lipoprotein near seven, but no physiological function has been ascribed to them.¹¹

Electrophoretic analysis of serum lipids by zone electrophoresis and staining with Oil Red O or sudan black dyes, has revealed two major fractions, alpha and beta, and has shown that most of the lipid increases in serum reside in the beta fraction. The alpha fraction can vary, but usually remains remarkably constant during induced serum lipid variations. Cholesterol and lipoproteins determined in the electrophoretically separated fractions grossly correlate in concentration with each other.⁴⁰

Carbohydrates: Carbohydrates affect lipid metabolism mainly through a "sparing action" by entering metabolic pathways to provide adequate calories for usual requirements more rapidly than lipids or proteins. Isocaloric substitution of starch for sucrose, glucose, and fructose apparently can lower the level of serum cholesterol.⁵⁴ Administration of glucose or insulin depresses the plasma fatty acid values.⁵⁸

Proteins: The center of the chylomicron is composed of protein with high binding capacity for lipids to form a particulate complex of triglyceride, cholesterol ester, phospholipid, and protein.^{10,60}

Dietary protein deficient in labile methyl groups apparently can cause hypocholesterolemia while pro-

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tein deficient in sulfur can lead to hypercholesterolemia.⁵ A comparison of the effects of dietary casein and wheat gluten suggests that both the quantity and type of protein influences the serum cholesterol in the rat.⁴⁸ When the diet contains 40 per cent casein, the serum cholesterol concentration reaches the lowest value for a casein diet, but will increase at higher or lower concentrations of casein. When the dietary protein is gluten, the serum cholesterol is lowered progressively as the level of gluten is increased from 10 to 68 per cent.

A decrease in protein content while the diet is kept isocaloric reduces the levels of serum cholesterol and phospholipid.²³ The reduction in serum lipids was found to be independent of a negative nitrogen balance. Lowered dietary protein coupled with administration of androgen caused further reduction in serum lipids. Low protein diets at a constant intake of fat has also caused a lowering of serum cholesterol and beta-lipoprotein levels.⁵⁰

Host Constitutional Reactions

Age: The apparent high percentage of cases of coronary thrombosis with elevated lipid and cholesterol levels causes apprehension about the significance of increasing levels of cholesterol as age advances. In men, levels of cholesterol steadily rise until beyond middle life while in women, they do not appreciably increase until after middle life.³ Empirically, greater numbers of yellow streaks, elevated calcium content, and increased ceroid (a wear and tear pigment) deposit occur concomitantly with advancing age.²⁷ Age per se is related to atherogenesis only in that it represents the passage of time under conditions favorable for the development of atherosclerosis.

Endocrine: Differences in incidence of coronary artery disease as well as in serum lipid levels exist between males and females.³ Large doses of estrogens can reverse the ratio of alpha to beta lipoproteins in males.⁴⁹ Growth hormone influences the rate of fat mobilization and metabolism by reducing fat stores, increasing liver fat, and raising fasting values of plasma unesterified fatty acids.⁵⁸ Desiccated thyroid, 1-thyroxine and 1-triiodothyronine reduce the serum cholesterol as well as lipoproteins with flotation constants between zero and 20, but not those between 20 and 400.⁶⁸ In a 40 year old patient with widespread xanthomata of the skin and tendons, severe thyrotoxicosis developed and caused the xanthomata to decrease visibly and the serum cholesterol to drop from 523 to 214 mg. per cent.⁴¹ After thyroidectomy, when the patient stabilized as euthyroid, the serum cholesterol values rose to 855

mg. per cent. A recent conference has reviewed the influence of hormones on lipid metabolism in relation to arteriosclerosis.¹⁸

Genetic: Anatomically, evidence suggests that persons with endomesomorphic body build have a greater susceptibility to clinical coronary heart disease.²⁵ Genetic biochemical abnormalities affecting atherogenesis are exemplified by hypercholesterolemia and hyperlipemia. This type of inheritance is called incomplete dominance since the severity of the condition is greater in the homozygote than in the heterozygote.⁷⁶ Genetic clotting defects have been recognized, but none have been associated definitely with hypercoagulability of blood. Psychologically, it is suspected that an individual can inherit the predisposition of poor adaptation, whereby stressful situations, via neurohormonal mechanisms,⁵⁷ can contribute to atherogenesis.

Obesity: The impression exists that increased death rates are associated with obese persons. More atherosclerosis has been observed in obese groups than in emaciated or average nutritional state groups.⁷⁵ Obese individuals do not always possess elevated serum cholesterol values, but increased blood cholesterol levels have been observed in overfed volunteers.³⁶ Interpretation of available facts strongly suggests that obesity itself, in the absence of hypercholesterolemia, diabetes, and hypertension, exerts no appreciable effect on atherosclerosis.⁵⁶

Environmental Influence on Host

Stress: Studies on effects of severe occupational stress reveal that highest serum cholesterol occurred during severe stress and lowest in periods of minimal stress.²² Serum cholesterol determinations taken after examinations gave values about 10 per cent higher than those taken during relaxed periods.^{73,70} Much speculation continues about the relation of stress to lipid metabolism and coagulation processes in atherogenesis.⁵⁷

Physical Activity: Recommendations are made for regular, moderate exercise,⁷⁴ since it appears that individuals who exercise regularly and moderately have less atherosclerotic heart disease than sedentary individuals.⁴⁶

Social Habits: Smoking and alcohol have been questionably related to atherosclerosis; no clear-cut evidence is available for drawing any definite conclusions. It is suggested that these social habits are not casually related to atherogenesis, but merely are a reflection of need for reduction of psychic stress which itself could directly promote atherogenesis.⁴⁵

Infections: It is interesting to speculate whether infections could predispose to atherogenesis. During

acute infection, serum cholesterol values are lowered below the usual level of the individual, but afterwards it returns to levels above pre-illness value.²⁷ It is possible that various microbiological agents as well as hypersensitive reactions, could cause initiation of atherogenesis by local injury to the vessel walls, but there is as yet no clinical evidence to support this.⁴⁷

Diet: The environmental factor which has received most attention recently in regard to atherogenesis is the diet. The most widely discussed studies have concluded that the fat content of the diet is a most important factor. It has been found that the type of fat rather than the total amount is probably the significant determinant of blood lipid concentrations. The unsaturated fatty acids have been observed to lower blood lipids while the saturated ones tend to cause elevation.^{6,33,36,38,48,51,56}

Summary of Probable Pathogenesis of the Atherosclerotic Process and Its Complications

Primary Injury to vessel wall results in: (1) gelatinous lesions, (2) fatty streaks, and (3) fibrin strands. These involve predisposing vessel wall condition.

Development of atherosclerotic lesion is mediated through: (1) lipid accumulation at site of injury, particularly in areas of increased centrifugal force of blood stream, and (2) clotted products. These involve predisposing blood conditions.

Progression to an advanced lesion involves a number of processes: (1) exudation, hemorrhage, intimal proliferation, and hyalinization; (2) scarring and plaque formation; (3) repeated micro-hemorrhages, ulceration, and (4) calcification.

Occlusion of the diseased vessel results from extension of advanced lesions, rupture of atheromata, rapid formation of an occluding clot, hemorrhage beneath a plaque raising it until it occludes the vessel.

The Effect of Diabetic State on Atherosclerosis

Diabetes, as well as hypertension, renal disease, hypothyroidism, hypercholesterolemia, and hyperlipemia, have been associated with increased incidence of atherosclerosis.^{1,13,16,21,27,44,71} Diabetes apparently exerts its influence through metabolic defects, infections, and stress.

Metabolic Defects: The major biochemical lesions that have been observed in diabetic individuals are: (1) fatty acid synthesis depression, (2) increased ketone body synthesis, (3) unpredictable variations in cholesterol synthesis, (4) depressed utilization of Krebs cycle, and (5) diminished ability to synthesize proteins.^{65,66} In diabetes, the synthesis of fatty acids is impaired, but their breakdown occurs satisfac-

torily. It is proposed that this is caused by a deficiency of the reduced form of triphosphopyridine nucleotide (TPN), resulting from a defective carbohydrate metabolic pathway that fails to produce the reduced form. Ketosis in clinical diabetes is characterized by the presence of an excess of ketone bodies, acetoacetic acid, and beta-hydroxybutyric acid, and apparently these accumulate because the metabolic block in fatty acid synthesis prevents their participation in synthesis of fatty acids. Cholesterol synthesis can be depressed or increased in the diabetic. Studies have confirmed that many patients with diabetes have "normal" or low cholesterol values although elevated values are more common.^{1,12} Decreased levels of intermediate reactants in the Krebs cycle and decreased protein synthesis in the diabetic liver, can also be linked to the deficiency of the coenzyme, reduced TPN.

Varying degrees of hyperlipemia exist among diabetic patients.⁸ In acidosis, the diabetic usually develops a cholesterol level almost twice the usual value while the triglyceride value increases ten fold.⁸ The frequent coexistence of diabetes and idiopathic hyperlipemia¹ raises the question of whether these two conditions might not result from closely related metabolic defects. Secondary hyperlipemia in diabetes is credited with removing the female resistance to atherosclerosis so that female diabetics can develop this disease just like non-diabetic males.^{1,71} Probably related to this is the fact that the average age of menarche of 222 girls who developed diabetic manifestations before age 11 is significantly later than the average of comparable control groups.⁵⁵

In poorly controlled diabetic patients, elevation of serum carbohydrate complexes occurs along with the increase in lipid fractions.⁴

The coexistence of obesity with diabetes is frequent,⁶⁷ but it is controversial whether there is more atherosclerosis in obese, diabetic patients than in non-obese diabetics. In an obese person, necessarily large quantities of mass and energy are continually involved in dynamic metabolism, and thus cause a continuing strain on the poor carbohydrate-handling ability existent in the obese diabetics.⁶⁷

In a study determining factors common to diabetes and atherosclerosis, beta globulins and beta lipids were found significantly elevated in both types of patients.¹⁵

Infections: The high frequency of infections in diabetes has been well established. Infections in diabetes probably can influence atherogenesis by decreasing the carbohydrate-handling capacity, and increasing the concentration of serum lipid components. The possibility of the viral or rickettsial infections being the source of the original insult on the

vascular vessel wall to initiate atherogenesis has not been substantiated.

Stress: Stress in diabetes can exert untoward psychological effects. Repeated infections, severe acidosis, cholelithiasis, ulceration of lower extremities, and defective eyesight are stressful situations that could promote the development or extend complications of atherosclerosis.

Diet: Most diabetic diets are high in total fat calories. The influence of this on development of atherosclerosis is not known.

Preventive Therapy of Atherogenesis in Diabetes

Very little information is available about therapeutic measures designed to control atherogenesis in diabetic individuals. Many physicians feel that the best therapy for control of excessive atherogenesis in diabetes is to keep the patient in good metabolic control, maintain well-being, and keep physical and mental stress at a minimum. The impression prevails that the frequency of atherosclerosis in diabetic patients who have never suffered from diabetic acidosis and who follow their control regimen, is no greater than that in healthy persons.³⁴ The suggestion has been made that not only should the diabetes be kept in good control, but it is important to maintain in a normal range both, (1) the blood pressure, to counteract local vascular factors, and (2) the serum lipids, to minimize the plasma factors suspected of enhancing atherogenesis.⁵⁶

No evidence suggests that additional measures beyond those reported useful for control of atherogenesis in non-diabetics, are indicated in the preventive therapy of atherogenesis in diabetic patients. Substances found variably in atherosclerosis and which must still be considered in the experimental stage, are estrogens,⁵⁹ nicotinic acid^{24,26} pyridoxine,²⁶ unsaturated fatty acids,^{6,37,38,42} plant sterols,²⁰ and thyroid hormones.⁶⁸ These affect lipid metabolism primarily and have been introduced on the assumption that proper control of lipid metabolism will limit predisposition and development of atherosclerosis. Of all of these, the proper use of the unsaturated fatty acids appears the most promising.

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FOREIGN FELLOWSHIPS FOR MEDICAL STUDENTS

A PROGRAM TO FURTHER international relations for the United States by making it possible for medical students to serve as unofficial ambassadors, has been announced by the Association of American Medical Colleges and Smith, Kline & French Pharmaceutical Company.

Established by a \$180,000 grant from Smith, Kline, and French, the new program will provide foreign fellowships through which students of United States medical colleges may travel abroad for a limited period of time to work in remote areas of the world.

These fellowships will provide selected medical students with broad clinical experience, an understanding of preventive medicine as practiced abroad, an opportunity to study diseases not common to the United States and a definite awareness of the acute need for American physicians and their medical knowledge abroad. In addition, this opportunity will afford the selected Fellow the chance to play the role of individual ambassador or missionary. He will be representative of the method of medical education in the United States today while communicating the most recent information available on medical science to distant areas of the world.

Any student who has completed his third year of medical school is eligible to apply for a fellowship. If accepted he may spend 12 weeks or more at a foreign mission or other remote private medical facility, or a public health unit, clinic or hospital.

The award of a fellowship will be determined on the basis of the applicant's ability, potential, and his objectives in wanting to study abroad. Emphasis will be placed on the applicant's plan for study and experiences which would not be afforded to the applicant at a medical school here in the United States and through which the student will bring back significant knowledge to the United States.

Cash awards will be made on an individual basis. A contribution to the expenses of the wife or husband accompanying the Fellow will be made when this seems desirable in terms of the objectives of the program and of the Fellowship. No awards will be made for the expense of children.

At the termination of time spent abroad, a Fellow is to write to report summarizing his clinical experiences abroad, including his personal evaluation of the effectiveness of the trip as a part of his medical education.

Medical students who wish to apply for a fellowship must submit their application to the dean of their medical school. If the application is acceptable, the dean will then endorse it and forward it to the Selection Committee at the Association of American Medical Colleges.

For additional information, contact Miss Diann H. Smith, Association Headquarters, DAVIS 8-9505 or BRoadway 3-4350, Evanston, Ill.

INTRAVENOUS CHOLANGIOGRAPHY IN THE DIAGNOSIS OF ACUTE CHOLECYSTITIS

A study of two hundred patients with "acute abdomen"

Henry C. Johnson, Jr., M.D., *Atlanta*

FOLLOWING THE INTRODUCTION of iodipamide (Cholografin®) for intravenous cholangiography in 1953, this contrast medium has been extensively utilized in the evaluation of a variety of chronic biliary tract disorders. A study conducted at the Grady Memorial Hospital in Atlanta over the past three and one-half years now affords data establishing the value of this method, in addition, as an emergency procedure in the differential diagnosis of acute cholecystitis.

Previous preliminary publications dealing with small numbers of patients have suggested the possible value of this method.^{1,2,3} The present study, however, constitutes the first large experience published and now includes approximately 200 patients with acute abdominal illness examined with emergency intravenous cholangiography. Of this group, 62 instances of acute cholecystitis have been documented.

Theory

The accepted pathogenesis of acute cholecystitis recognizes cystic duct obstruction as an essential pathologic feature of the disease. Based on this concept, one would anticipate inability to opacify the gall bladder in acute cholecystitis. On the other hand in acute non-cholelithic disease, as in the normal patient, the absence of cystic duct obstruction should permit gall bladder opacification to occur provided opacification of the biliary duct system is accomplished.

Demonstration of the presence or absence of cystic duct obstruction was therefore the objective

of this study. Intravenous iodipamide, excreted by the liver in sufficient concentration to opacify the duct system in most patients, thus affords a suitable means of identifying this phenomenon.

Technique of Examination

In this group of acutely ill patients cholangiography was in most instances accomplished as an emergency procedure without preliminary preparation. An intravenous test dose of 1-3 cc. of 50 per cent iodipamide methylglucamine was followed by an observation period of 3-5 minutes. If no untoward sensitivity was apparent the remainder of the 20 cc. dose was administered intravenously over the next five minutes. Roentgenograms in prone LAO position with Potter-Bucky diaphragm were obtained at ten, 20, and 30 minutes after injection. Findings on these roentgenograms determined the necessity for and the timing of subsequent films.

The incidence of minor side reactions approximated those reported elsewhere. No serious reaction and no death was attributed to the contrast agent.

Patient Selection

During this three and one-half year period cooperation of the surgical and medical staff was elicited in referring for cholangiography, whenever feasible, all in-patients and out-patients presenting acute symptoms suggestive of cholecystitis. Approximately 200 have now been studied. The subsequent clinical course, laboratory data, and results of surgical exploration and pathologic examination have been analyzed in each patient. In view of the

Presented at the *105th Annual Session of the Medical Association of Georgia, May 18, 1959, Augusta, Georgia.

preference at this institution for early surgical intervention in acute cholecystitis, a final diagnosis was possible in almost all instances in which the clinical and/or cholangiographic findings pointed to this disease.

To be included in the present study for analysis, two criteria were established:

1. The patient, regardless of the nature of the diagnosis subsequently proven, must have had the intravenous cholangiogram performed within the first seven days of the acute clinical illness. This criterion was established in an effort to assure that the acute phase of the disease was operative at the time of examination.

2. A proven diagnosis of acute cholecystitis was accepted in this series for analysis only when documented by histologic examination of the gall bladder specimen obtained at surgery or necropsy. The only exceptions in the group of 62 patients are two who are included because the gangrenous nature of the gall bladder at surgery permitted only a cholecystostomy.

Results

Findings on emergency cholangiography in these 200 acutely ill patients are graphically presented in Figure I. Note that the procedure afforded no information when hepatic excretion of the contrast medium was insufficient to opacify the biliary duct system (approximately 40 per cent of all patients). However, when duct opacification was obtained it was then possible to regularly determine the presence or absence of cystic duct obstruction. This finding correlated 100 per cent with the presence or absence of acute cholecystitis in this series of patients.

Patterns of Excretion

The three basic excretion patterns and their significance are recorded in Figure II.

PATTERN I: Opacification of Biliary Ducts and Gall Bladder.

Gall bladder opacification reliably excluded the presence of acute cholecystitis. These findings support the concept that cystic duct obstruction is an essential feature of the disease.

On theoretical grounds one must assume that varying degrees of cystic duct obstruction exist and that rarely the gall bladder may opacify even when acute obstructive cholecystitis is present. However, our experience has as yet failed to document such an occurrence. In addition, since original exhibition and publication of our preliminary results^{4,5} we have investigated four instances reported to us in which gall bladder opacification was believed to have been observed in patients with acute cholecystitis. In each instance, however, procurement of the original chol-

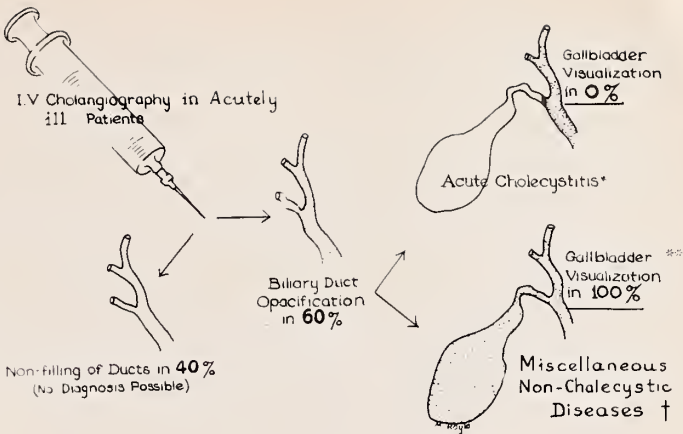


Figure I: *In acute cholecystitis, opacification of biliary ducts was never followed by gall bladder visualization, thus demonstrating cystic duct obstruction. **In non-cholelithic acute diseases, opacification of biliary ducts was always followed by gall bladder visualization, thus demonstrating patency of the cystic duct.

angiograms and histologic slides failed to document the observation. Although a false negative cholangiographic diagnosis of acute cholecystitis is a possibility, the experience cited suggests that it will be encountered with exceptional rarity.

PATTERN I-A: Delayed Visualization of Gall Bladder Only.

If hepatic excretion is poor or roentgenograms are of inferior quality gall bladder opacification may occasionally be observed on delayed films at 2-24 hours even when duct visualization was not obtained. This finding has the same significance as Pattern I, indicating the absence of cystic duct obstruction.

PATTERN II: Opacification of Biliary Ducts Without Ensuing Gall Bladder Visualization.

This pattern of excretion, confirming cystic duct obstruction, proved specific for acute cholecystitis. It was not demonstrated in any of the miscellaneous

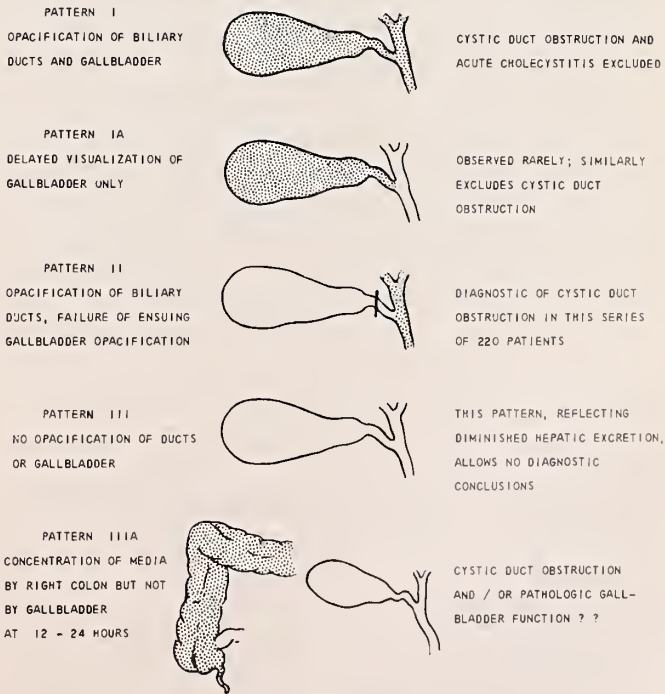


Figure II: Patterns of excretion.

INTRAVENOUS CHOLANGIOGRAPHY / Johnson

acute diseases encountered in these 200 patients.

The notable absence of false positive cholangiographic diagnosis of cystic duct obstruction in this study is attributed in large measure to the use of a delayed four hour post-injection roentgenogram. Previous observers who have encountered occasional false positive cholangiographic evidence of cystic duct obstruction have adhered to the conventional two hour radiographic study. Our experience, however, indicates that a two hour follow-up may be insufficient if initial duct opacification is of less than excellent density. A four hour post-injection film has been found reliable in all instances, however. *The premature diagnosis of cystic duct obstruction based on roentgenograms obtained for only one or two hours after injection has been found the outstanding pitfall in emergency cholangiographic interpretation.*

PATTERN III: No Opacification of Ducts or Gall Bladder.

This pattern of excretion was surprisingly encountered in 40 per cent of patients and prevented any conclusion as to the presence or absence of cystic duct obstruction. A companion study of the hepatic uptake of radioactive Cholografin® has demonstrated frequent impairment of liver function, at least transitory, in the acutely ill patient.⁶ It is to be emphasized that the majority of our patients were dehydrated from repeated emesis and emergency cholangiography was usually performed before intravenous replacement of fluid and electrolytes had been accomplished. Transient alteration of liver function is apparently the mechanism of non-visualization in these patients. It was not uncommon to obtain duct opacification 24 hours later, following intravenous alimentation.

PATTERN III-A: Delayed Concentration of Media by Right Colon but not by Gall Bladder at 18 to 24 Hours.

Delayed abdominal roentgenograms at 18 to 24 hours were obtained in only a few patients in this study. Significant conclusions are therefore not possible. However, in each of nine patients showing concentration of the contrast media in the right colon after no visualization of the biliary ducts or gall bladder, significant gall bladder disease was subsequently

TABLE I

Diseases which Clinically Simulated Acute Cholecystitis Until a Normal Intravenous Cholangiogram Directed Attention Away from the Gall Bladder.

Acute Pancreatitis	Dissecting Aortic Aneurysm
Acute Appendicitis	Pleurodynia
Perforated Peptic Ulcer	Right Ureteral Calculus
Pneumonia	Simple Gastroenteritis
Right upper lobe	Acute Alcoholic Gastritis
Right lower lobe	

demonstrated. Further observations appear warranted to determine whether selective concentration of the intravenous medium by the colon (indicating biliary excretion), but not by the gall bladder, warrants a diagnosis of impaired gall bladder function.

Specific Recommendations in Emergency Intravenous Cholangiography

To minimize patient discomfort, diagnostic errors and instances of nonvisualization certain techniques have been found pertinent:

1. If the clinical situation is not urgent, a few hours devoted to correction of the dehydration and electrolyte imbalance will substantially reduce the incidence of non-visualization of the duct system. In this manner the diagnostic yield of the procedure is increased.

2. If biliary duct opacification has not appeared within 30 minutes after intravenous injection of iodipamide, the procedure can be terminated as of no diagnostic value. Delayed films at six to 24 hours will occasionally provide unexpected information.

3. When early duct opacification is of excellent density and ensuing roentgenograms are of good quality, a diagnosis of cystic duct obstruction is warranted if gall bladder opacification has not appeared on the two hour post-injection roentgenogram.

However, when early duct opacification is of less than excellent density a diagnosis of cystic duct obstruction is reliable only when roentgenograms are followed for four hours after injection.

Intravenous Cholangiography in Acute Non-Cholecystic Diseases

During this three and one-half year study the most frequent situation in which decisive clinical information was obtained involved those patients whose acute illness suggested a diagnosis of cholecystitis to the attending physician, but in whom the emergency cholangiogram refuted this diagnosis. In many such instances unnecessary abdominal surgery was avoided and clinical attention was directed away from the gall bladder and to the true source of symptoms (Table I).

The frequency with which emergency cholangiography has resulted in decisive information in patients with inconclusive clinical findings has been noteworthy.

Summary and Conclusions

1. Emergency intravenous cholangiography has been performed in approximately 200 patients with signs and symptoms clinically suggestive of acute

cholecystitis. Subsequent data have documented this diagnosis in 62 patients.

2. Cystic duct obstruction appears to be an essential feature of acute cholecystitis and is a phenomenon which can be directly identified or excluded by this procedure.

3. Certain pitfalls in emergency cholangiography are enumerated, the avoidance of which has eliminated false positive and false negative cholangiographic diagnoses of acute cholecystitis in this study.

4. The adoption of intravenous cholangiography as a routine procedure in patients with suspected acute cholecystitis has substantially reduced diagnostic errors in our institution.

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LIBERALIZATION OF SOCIAL SECURITY PROGRAM

OVERSHADOWING ALL OTHER developments from the standpoint of the medical profession was the flat prediction from a high Administration official and key lawmakers that Congress this year would vote some sort of liberalization of the Social Security program.

There was general agreement that Congress would broaden the Social Security plan for permanently and totally disabled persons by removing the requirement that a person has to be at least 50 years of age before receiving such benefits.

However, there were forecasts of even further liberalization. House Speaker Sam Rayburn (D., Texas.) said monthly cash benefits also may be boosted. On the other hand, the House leader said he believed a majority of the House Ways and Means Committee were opposed to the disputed Forand bill that would finance partial health care for the elderly through higher Social Security taxes at an estimated extra cost of \$2 billion annually. As a result, he said he did not think "there was a great deal of chance for it." But the AFL-CIO and some Congressional backers of the highly controversial bill were urging Congress to approve it this year.

Arthur S. Flemming, Secretary of Health, Education and Welfare, asserted that the Administration is planning to offer a program aimed at assisting needy aged to meet health bills, but gave no details. The official noted that the Administration has firmly opposed the Forand-type approach on grounds it would destroy the rapid progress in meeting the problem through private means. But Flemming, in a speech before the American Association of University Teachers of Insurance, said the Administration has an obligation "to stay with it" until it arrives at a plan.

Congress has extended the Social Security program every presidential election year since 1948, and 1960 appeared to be no exception. Whether or not the issue of medical care for the aged will be included was one

of the big question marks early in the session.

Shortly before Congress convened, the Boards of Trustees of the AMA and the American Hospital Association, in a joint resolution, pledged to "mobilize their full resources to accelerate the development of adequately financed health care programs for needy persons—especially the aged needy—" at state and local levels.

The Boards said Forand-type legislation is "not designed to assist to the needy, since they apply to all Social Security beneficiaries and exclude the majority of needy persons, who are not eligible for Social Security benefits."

Following the action, Dr. Louis M. Orr, AMA President, and three other AMA officials—Dr. E. Vincent Askey, AMA President-Elect, Dr. F. J. L. Blasingame, Executive Vice President, and Dr. Ernest B. Howard, Assistant Executive Vice President—visited Vice President Richard M. Nixon at his Washington Office. They told the Vice President that by the end of this year an estimated 60 per cent of the nation's aged persons who want and need voluntary health insurance will have it.

Mr. Nixon, according to the officials, was delighted to receive the information and "very much interested" in the program of voluntary health insurance for the aged.

Notes

Physicians who are officers of qualified clinics would be entitled to deduct as business expenses money set aside for their retirement under a proposed regulation of the Internal Revenue Service. The decision climaxed a five-year effort of a group of Montana physicians to to secure such tax treatment, and marked an important tax development for physicians who operate clinics. Self-employed physicians continue to be barred from similar tax treatment, though there is legislation before the Senate Finance Committee that would afford them tax deferrals on funds set aside for retirement.

COLUMBUS—YOUR HOST CITY

W. C. Woodall, *Columbus*

TEXT—FROM THE APOSTLE PAUL: *I am a citizen of no mean city:*

On December 24, 1827, the heart of the Governor of Georgia was mellowed with the spirit of the blessed season, and he longed to do some good and memorable deed. So he signed the legislative act bringing into being the Town of Columbus, on the Chattahoochee River, at the extreme west border of the State. It was Governor's gracious Christmas gift to Georgia and to the nation.

The Legislature picked this as an ideal spot where a city ought to be. It was the head of navigation of the Chattahoochee, Georgia's longest river. It was at the foot of a series of falls extending more than 30 miles—the furthest-south great waterpower in the country.

The opening of the sale of lots at the new trading town was exciting and colorful. Present in the large assemblage were Governor Forsyth and many members of his staff, camped on a bluff of the river near a bold, clear spring.

Steamboats from the Gulf of Mexico beat the Governor and his party to the spot by several months. Before long they were coming at the rate of two or three a week, bringing passengers and freight to a new town already acquiring fame. In the next century more than 200 steamboats were to ply the Chattahoochee, between Columbus and the Gulf. Most of them died with their boots on—either burned or sunk by shifting snags.

The engineers laid out the streets of the new city broad and ample. At last they could plan a town like they wanted to. It was not a real estate transaction. They had plenty of land.

In the center of the city a large block was set aside for religious purposes. It was envisioned to provide another possible service before churches were built there; in event of Indian attack, a stockade was to be built on the block and women and

children were to be herded there for safety. What was to be a refuge for bodies became through the years a refuge for souls. Two of the city's great churches now stand on the lot.

The new town began manufacturing before it was a year old. In the 1830's the textile industry got a brisk new start here. In 1900 a correspondent of the New York *Sun* came to Columbus. He wrote his paper: "There is a city in Massachusetts which may be called the Columbus of the North. It is Lowell." Today Columbus ranks second in the South in cotton manufacturing.

Columbus has furnished many famous personages to the world. Mirabeau B. Lamar, the city's first editor, became Vice-President and then President of the new Republic of Texas. The newspaper he established is still published.

The Straus brothers—Oscar, Nathan, and Isidor—went from Columbus to New York to gain fame in diplomacy, merchandising, and philanthropy.

George Foster Peabody, noted financier and philanthropist, was a Columbus boy who went to New York to make his fortune.

Columbus provided the Southern Railway with its first president—Samuel Spencer.

Theodore O'Hara, a Columbus school teacher, wrote the immortal lines:

On fame's eternal camping ground
Their silent tents are spread,
And glory guards with solemn round
The bivouac of the dead.

Captain O'Hara was a native of Kentucky, and that state proudly claimed its own. His body was removed from Linwood Cemetery, Columbus, and his last resting place in Kentucky is marked by a monument.

A beloved Columbus physician has his own en-

during place in the literary Hall of Fame. He was Francis Orray Ticknor, a war-time doctor and poet. He wrote the undying lines:

Out of the focal and foremost fire—
Out of the hospital walls as dire—
Smitten of grapeshot and gangrene—
Eighteenth battle and he, sixteen—
Specter such as you seldom see—
Little Giffen of Tennessee.

And we watched the war with abated breath,
Skeleton boy against skelton death!—
Months of torture, how many such!—
Weary weeks of the stick and crutch,—
And still a glint in the steel-blue eye
Told of a spirit that wouldn't die.

The good doctor, it was said, often wrote his poems on his saddlebags, as he rode from patient to patient. He is to have place later in this narrative.

The most famous personage that ever came out of Columbus, Georgia was a half-witted Negro boy who had been born a slave— Blind Tom, musically untrained, who had the strange and magic gift of reproducing on the piano the songs of birds, the timbre and lilt of human voices, the noises of nature and even the sound and fury of the Battle of Columbus. He gave performances throughout the United States and played before royalty in Europe. Innumerable articles were written about him and books are planned or are in process about one whose marvelous gifts perplexed the musical world and enchanted the populace.

One of America's distinctive monuments rests over a grave in a colored cemetery in Columbus. It honors the memory of Bragg Smith, a Negro laborer who sacrificed his life in a brave but fruitless attempt to save that of the city's superintendent of public works in a caving trench. It was placed there by a grateful city. This possibly is the only memorial of its type, erected by a municipality, in the entire United States.

A tremendous railroad building era dawned in the South in the 1840's. No city could have been more enterprising than Columbus. In that decade and in succeeding years, seven railroads were built into the city. Bond issue after bond issue went to assist in the building of these projects. Some of them in amount were truly remarkable for a little city of that size. Up to 1900 the only bonds that the City of Columbus had ever issued had been for railroads.

When the War Between the States began, company after company went from Columbus to the battle lines. It is claimed that Columbus furnished more

troops to the Southern Confederacy, in proportion to population, than any other city.

Already an industrial city of importance, Columbus during the war years was busy manufacturing goods for the Southern Confederacy. There was a wide range of products, from cotton goods to gunboats. What was claimed to be the world's first breech-loading cannon was made here. There was a sword and pistol factory employing 400 boys. The men were at war.

April 16, 1865, a week after Appomattox, the last staged battle in the War Between the States was fought at Columbus. The next day the victorious federal forces burned every factory in Columbus save one; railroad yards and freight cars; cotton and warehouses; everything that might have any possible military significance. Forty-three million dollars worth of cotton was destroyed.

The one factory saved from the torch was owned by a Union sympathizer who had kept a United States flag flying secretly in the cupola of the building during the war years.

Among the plants utterly destroyed was that of the Columbus Iron Works which, during the war years, was operated as the Naval Iron Works by the Confederate Government. The personal fortunes of its owners had been wiped out.

The company's stockholders met to decide whether to attempt to continue, or to abandon, the business. It was decided to continue operation—and to double the capital stock! A few years later this company became the first in the world to manufacture ice machines commercially.

Among the cotton mills burned was the Eagle. Plans to rebuild were made at once. When it rose from the ashes they called it the Eagle and Phenix.

In the closing period of the War Between the States, Columbus became a great Confederate hospital center. Facilities for 1500 beds were provided. The county courthouse was made half-hospital. Eight buildings on Broad Street, including two saloons, were rented and equipped as hospitals. Located at the town's edge was Camp Montgomery, a large convalescent hospital. Dr. Francis Orray Ticknor was its chief surgeon. By May 1864 the Columbus army hospital had 1,350 patients.

In the early part of 1866 Columbus originated Confederate Memorial Day. The thought first sprang in the patriotic heart of Lizzie Rutherford. The beautiful letter to the Southern press urging the establishment of Memorial Day, and that it be observed on a common date, was written by Mrs. Charles J. Williams, secretary of the Ladies' Memorial Association, successor to the Soldiers' Aid Society, which had operated during the war years. The

date suggested by these Columbus women for Memorial Day—April 26—was adopted by the South. It has been observed every year since then in Columbus.

In 1867 Columbus became one of the pioneers in the South in establishing a public school system. It was the second Georgia city to have that distinction; Savannah had built a public school a few months before.

In 1906 Columbus established the Secondary Industrial High School, a great step forward in education. It was claimed that this was the first vocational training school in the world, operated by a municipality, open to both sexes.

Columbus furnished the inspiration for two of the greatest names in soft drinks. Dr. John S. Pemberton, for long years a Columbus druggist, originated the formula for "Coca-Cola" and was one of the founders of that company. A Columbus wholesale grocer, formerly a druggist—Claude A. Hatcher—created "Chero-Cola", the predecessor of the present "Royal Crown Cola".

In 1917 Uncle Sam was looking the country over in a certain little matter. He was searching for an ideal location for an Infantry School, where climate, terrain and everything was just right. He found it in a broad section south of Columbus containing every variety of terrain and physical conditions needed for adequate military training. It was called Fort Benning, named for General Henry L. Benning, a gallant Confederate Army officer who had lived in Columbus. With its 182,000 acres of training grounds, the U. S. Army Infantry Center is today the world's largest infantry school of its type. Fort Benning has had at times a military population

of 100,000. All our famed Army men of modern times have been there, some of them in administrative capacities.

With the building of the great Oliver Dam, development of the waterpower between Columbus and West Point has been completed. The last of the horses that formerly flung their white manes in wild and riotous freedom have been tamed to do the bidding of man.

Eighty river miles to the south of Columbus near Fort Gaines, the great Walter F. George Dam is now raising its giant form against the sky, the largest development project on the lower river. The locks there will lift water 88 feet. Scheduled for completion in the Spring of 1963, the dam's back waters will provide a channel nine feet deep, 100 feet wide, to the wharves of Columbus and Phenix City. Actual navigation to this city is expected to begin in December, 1962. The lake to be created will be one of 45,000 acres and it will be well filled by the end of 1962.

Columbus is a city of great variety in manufactured products and ranks as one of the leading industrial centers in the South.

Columbus and Savannah are now racing for the honor of being Georgia's second largest city. Columbus claims that in metropolitan population it is already ahead. Savannah cannot reach out into the Atlantic Ocean and commandeer the crews of passing ships as Metropolitan District inhabitants. But Columbus does turn to adjacent populous Alabama to further buttress its figures. However, there is population and glory enough to go around, and it is a friendly rivalry.

JOB CALDWELL PATTERSON

WHEREAS, Dr. Job Caldwell Patterson, died suddenly on November 8, 1959, at his home in Cuthbert, Georgia, and

WHEREAS, Dr. Patterson, had led a most distinguished and useful life serving his country during World War I as Director of the Field Hospital of the 31st Division in France; serving organized medicine as President of the Medical Association of Georgia in 1940-41, and at other times serving his District Society, his County Society, and the Georgia Chapter of the American College of Surgeons as President; serving his community as County Physician, member of the County Board of Health, Past President of the Cuthbert Rotary Club, and as Trustee of Andrew College, and

WHEREAS, Dr. Patterson, by his kindness, integrity,

and exemplary life had won the love, respect, and honor of his family, his associates, and his medical colleagues throughout the state, and

WHEREAS, Dr. Patterson, had been a most diligent and respected member of the Board of Directors of the Physicians Service, Inc., of Columbus, Georgia, from almost the inception of the Blue Shield Plan, giving fully of his time, his wisdom, and level headed advice in the development of Blue Shield in Georgia, now therefore,

BE IT RESOLVED, that the Board of Directors express our love and esteem for Dr. Job Patterson, to his family, his associates, and his friends and that copies of this resolution be sent to his family, to the Medical Association of Georgia, and to his associates, and further that a copy of this resolution be spread upon the permanent records of this organization.

The Above Resolution was unanimously adopted at the January 30, 1960, Annual Meeting of the Blue Shield Board of Directors.

1960 CALENDAR OF MEETINGS

State

May 1-4—Annual Session, Medical Association of Georgia, Municipal Auditorium, Columbus.

Oct. 12-13—Annual Meeting, Georgia Academy of General Practice, Dinkler Plaza, Atlanta.

Regional

April 8-12—Florida Medical Association, Robert Meyer Hotel, Jacksonville, Florida.

April 9-12—Texas Medical Association, Hotel Texas, Fort Worth, Texas.

April 10-13—Tennessee State Medical Association, The Maxwell House, Nashville, Tennessee.

April 13-15—American Public Health Association, Southern Branch, Memphis, Tennessee.

April 21-23—Medical Association of the State of Alabama, Admiral Semmes Hotel, Mobile, Alabama.

May 2-4—Louisiana State Medical Society, Capitol House, Baton Rouge, Louisiana.

May 7-11—North Carolina Medical Society, Hotel Sir Walter Raleigh, Raleigh, North Carolina.

May 10-12—Mississippi State Medical Association, Hotel Heidelberg, Jackson, Mississippi.

May 17-19—South Carolina Medical Association, Ocean Forest Hotel, Myrtle Beach, South Carolina.

Sept. 14-16—Southern Trudeau Society and Southern Tuberculosis Conference, Hotel Francis Marion, Charleston, South Carolina.

Oct. 31-Nov. 3—Southern Medical Association, St. Louis, Missouri.

National

March 31-April 2—American Gastroenterological Association, Roosevelt Hotel, New Orleans, Louisiana.

April 1-3—American Society of Internal Medicine, Sheraton-Palace Hotel, San Francisco, California.

April 4-9—American College of Physicians, Mark Hopkins and Fairmont, San Francisco, California.

April 8-12—American Dermatological Association, Inc., Boca Raton Hotel, Boca Raton, Florida.

April 25-30—American Academy of Neurology, Eden Roc Hotel, Miami, Florida.

May 5-8—Student American Medical Association, Statler-Hilton Hotel, Los Angeles, California.

May 9-13—American Psychiatric Association, Inc., Hotel Traymore, Atlantic City, New Jersey.

May 15-20—National Tuberculosis Association, Statler and Biltmore Hotels, Los Angeles, California.

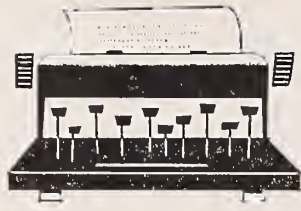
May 16-18—American Trudeau Society, Statler and Biltmore Hotels, Los Angeles, California.

May 30-June 1—American Gynecological Society, Williamsburg Inn, Williamsburg, Virginia.

June 5-28—Fifth Medical Seminar Cruise, Duke University School of Medicine, to the Baltic, leaving from Wilmington, N. C. June 5 or New York, June 8.

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editorials

Annual Session in Columbus

THE DOCTORS OF GEORGIA will meet in the *106th Annual Session of the Medical Association of Georgia at Columbus on Sunday, May first through Wednesday, May fourth. This will mark the first time in recent years that such a session has been held in Columbus. Along with its rapid growth as a metropolitan center within the past 20 years, greatly expanded hotel and motel facilities have made it a logical meeting place for future annual sessions. Metropolitan Columbus experienced a phenomenal growth during the 1940-1950 decade. The U. S. Census reveals a population of 126,000 in 1940 and 170,000 in 1950. The 1960 census will doubtless show a comparable increase. Because of this vigorous population growth and the development of superior hospital facilities, many well trained and outstanding doctors have located in Columbus. Since the days of the War Between the States, Columbus has figured prominently in medical development within the state. The Confederate government established a large system of hospitals in Columbus in the last period of the War. In February of 1864 owing to serious overcrowding of Confederate hospitals in the Atlanta and Dalton areas, Columbus was selected as the site of a 1,500 bed Army hospital.

Columbus also figured prominently during the War Between the States as a manufacturing city for the Confederacy. The largest sword factory in the South was located there. The Columbus Iron Works made many products including gunboats for the Confederacy. It is also of interest that the last important land battle of the War resulted in the capture of Columbus by Federal forces on April 16, 1865. The first Confederate Memorial Day was celebrated in Columbus April 26, 1866, and has since become

generally observed throughout the South.

Since 1865, Columbus has developed into the trade center of a large agricultural district. The city has well known manufacturing industries which include cotton mills, iron and steel mills, cottonseed oil mills, peanut factories, carbonated beverage plants, and agricultural implement works. The world's largest infantry training school, Fort Benning, is located adjacent to Columbus and has figured prominently in the city's development.

Many imminent persons have had their origins in the Columbus area. Among them are the late George Foster Peabody, the philanthropist, churchman, and generous friend of education. Public education has long been prominent in the life of Columbus. In 1867 a group of citizens established a public school, making Columbus one of the first Southern cities to have a public school system. The city has continued to hold a position of leadership with its school system.

The program chairman for the various specialty groups have been particularly fortunate this year in obtaining a number of outstanding speakers for the scientific program. At the General Session on Sunday night we will be honored by an address by the Governor. The alumni groups and specialty societies have planned excellent programs for their luncheons and dinners. The Woman's Auxiliary has planned many interesting features for the wives. The scientific exhibit committee has many outstanding entries and the competition will be keen for their award. Commercial exhibitors will be present with their always attractive booths and very popular give-away sample items.

Set aside May first on your calendar for the best M. A. G. Annual Session yet, in Muscogee.

"Obstructive" Jaundice Due to Drugs

IT IS APPARENT that many physicians are not aware of the fact that certain drugs are capable of causing a toxic reaction manifested by jaundice which results in laboratory findings very similar to and often identical with those of obstruction of the common bile duct. If the physician fails to realize this, the patient may be subjected to an unnecessary laparotomy for relief of common bile duct obstruction when no such obstruction exists.

Regurgitation jaundice is usually recognized by a prompt direct van den Bergh reaction. The urinary urobilinogen is usually low. The cholesterol and alkaline phosphatase levels in the blood tend to be elevated and the patient often complains of itching. The stools are apt to be pale. The urine tends to be dark yellow. Cephalin flocculation and thymol turbidity tests are apt to give fairly normal results.

Unfortunately, certain drugs may be responsible for practically identical findings. These include chlorpromazine (Thorazine®), arsphenamine, methyltestosterone, thiouracil, cinchophen, norethandrolone (Nilevar®), possibly sulfadiazine and similar compounds, methimazole (Tapazole®), aurothio-glucose, manganese salts, and other chemical substances. The changes found in the liver are often referred to as "cholangiolitic hepatitis".

Patients who present this picture should be questioned carefully for a history of exposure to any of the drugs mentioned above as well as to the commoner modes of transmission of viral hepatitis. This jaundice from drugs is apparently due to the presence of bile thrombi localized in the finer bile

capillaries. Even liver needle biopsy may not clarify the diagnosis. Liver biopsy specimens present a difficult differential diagnosis inasmuch as similar histological changes may be seen in extrahepatic obstruction.

The toxic effects mentioned above should be differentiated from the direct toxic effect of such agents as carbon tetrachloride, chloroform, trichloroethylene, cinchophen, tannic acid, gold salts, and other heavy metals, which has long been recognized as a cause for serious and at times fatal damage to the liver as a result of a diffuse necrotizing process involving chiefly the hepatic parenchyma.

This editorial seeks to call attention to the fact that certain drugs produce jaundice by directly affecting the excretory processes in the liver. The essential histological changes in the liver seem to be those of a nonsuppurative cholangitis or cholangiolitis, with the production of bile thrombi in the canaliculi. As a rule, there is little or no damage to the liver parenchyma, although this may occasionally occur in severe cases.

Laboratory findings are primarily those of interference with normal biliary excretion, hyperbilirubinemia of the direct type, hyperphosphatasemia, hypercholesteremia, and increased BSP retention. Eosinophilia may occur, suggesting that this is due to allergy.

Withdrawal of the drug and adequate supportive measures are usually accompanied by the ultimate and complete reversal of the pathological process in the liver.

Differential Diagnosis of Chronic Idiopathic Jaundice

THE CAUSE OF CHRONIC or recurrent jaundice is often difficult to determine without the help of liver biopsy. Nearly every physician can remember patients who appeared to have obstructive jaundice, but when surgical exploration was performed, the bile passages were found patent. Occasionally as an

explanation, spasm of the sphincter of Oddi or intra-hepatic obstruction has been given.

Recently two untreatable clinical entities characterized by chronic or recurrent jaundice with good prognosis have been described. All attempts should be made to rule out either of these before an explora-

tion for chronic jaundice is undertaken.

The first of these entities is known as Gilbert's Disease (also Non-spherocytic Hyperbilirubinemia or Chronic Acholuric Hyperbilirubinemia) and is relatively easy to diagnose. In this disease the indirect serum bilirubin is increased while there is no bilirubin in urine. The defect appears to be in the enzyme glucuronyl transferase which effects the conjugation of bilirubin with glucuronic acid. Normally this results in the conversion of the Van den Bergh indirect bilirubin, which is not soluble, into soluble and excretable direct bilirubin.¹ This disease differs from hemolytic jaundice in that there is no detectable abnormality of the red cells, and there is no anemia or splenomegaly.

The second entity is Chronic Idiopathic Jaundice. This disease was first described by Dubin and Johnson² in 1953 and independently by Spritz and Nelson in 1954.³ It has been called Dubin-Johnson's Disease, Chronic Idiopathic Jaundice, and Mavrohepatic Jaundice. The disease is infrequent, but not rare. Since first described in 1953, Dubin⁴ had collected 50 cases by 1958 and more have been published since. The cause of the jaundice is not explained. Grossly the liver varies in appearance from dark green to an almost black. On microscopic examination has been noted coarsely granulated pigment in the liver cells, predominantly in the central portion of the hepatic lobules. This pigment has the staining properties of lyphofuchsin. There is usually a history of long duration or of recurrent bouts of jaundice. Also frequently there is a history of jaundice among the relatives. Clinically there are no characteristic findings. The patient usually has a consistently elevated serum bilirubin, but jaundice becomes clinically evident only during episodes of some unrelated infection, febrile disease, physical or mental stress.⁴

The patient frequently complains of right upper quadrant abdominal discomfort or pain. In a case observed by the undersigned, the only complaint was persistent itching. During exacerbations there may occur nausea, vomiting, anorexia, and fatigue. These symptoms together with increased direct bilirubin in serum, the appearance of bilirubin in urine, and the failure of the gallbladder to visualize on oral cholecystography make the differentiation from chronic obstructive jaundice very difficult. Of 50 patients collected by Dubin,⁴ 30 had exploratory laparotomy for suspicion of obstructive jaundice.

In spite of the similarity between chronic obstructive jaundice and Dubin-Johnson's Disease, the correct diagnosis may be suspected with the help of the

laboratory. Bromsulphalein retention is usually increased, but not as much as one would expect from the intensity of the jaundice. Other tests, such as flocculation tests, turbidity tests, cholesterol, prothrombine time, and serum proteins are normal, or during exacerbations, only slightly abnormal. Most helpful is a normal alkaline phosphatase in Dubin-Johnson's Disease when compared to an elevated alkaline phosphatase usually found in obstructive jaundice. Also in Dubin-Johnson's Disease urinary urobilinogen tends to be normal or elevated, while being normal or reduced in obstructive jaundice, depending on the completeness of the obstruction.

Liver biopsy is diagnostic. In a particular case it may be difficult to decide between the less dangerous needle biopsy and the more informative exploratory laparotomy. The difficulty lies in the fact that among 30 patients collected by Dubin who had laparotomy, five had biliary calculi in the gallbladder. This is an incidence of 16 per cent which may be statistically significant if one considers that the majority of Dubin's cases were young males. So far no complications from calculi have been observed among the known cases of Dubin-Johnson's Disease. Such may though be anticipated as more cases are found and followed through longer periods of time. It is yet to be found how these cases will tolerate an additional insult to the liver such as a common duct obstruction due to a calculus. It is evident that the liver excretory reserve is reduced since unrelated conditions, such as febrile diseases, surgery or mental stress usually provoke an exacerbation of the jaundice. In most cases needle biopsy is adequate for diagnosis, but occasionally surgical exploration may be the better choice. In a number of cases the history and the basic laboratory studies will be sufficient in establishing the diagnosis of Chronic Idiopathic Jaundice. When this diagnosis has been made, the patient should be assured of the innocence and good prognosis of his disease. No other treatment is known.

Bozidar F. Voljavec, M.D.
Battey Hospital
Rome, Georgia

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3. Sprinz, H. and Nelson, R. S.: Persistent Nonhemolytic Hyperbilirubinemia Associated with Lipochrome-like Pigment in Liver Cells: Report of Four Cases, *Ann. Int. Med.* 41:952, 1954.
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Your Journal Grows

WITH THE CURRENT issue of the Journal of the Medical Association of Georgia we are proud to initiate two new feature pages for our readers.

The Mental Health Page sponsored by the Mental Health Committee of the Journal of the Medical Association of Georgia will be published monthly and promises to serve a very useful function for the busy practicing doctor. These brief articles will be prepared at the request of the committee by representatives from all the specialties and will cover

timely material of interest to most physicians regardless of his special interest.

The Legal Page to be published bimonthly will be prepared by the Legal Counsel of the Medical Association of Georgia. This feature will cover questions in the legal area which will be of general interest to physicians. The subject matter will largely be dictated by requests from readers. If there are any topics you would like discussed, let us hear from you.

GOVERNOR VANDIVER PROCLAIMS HEART MONTH

GOVERNOR ERNEST VANDIVER proclaimed February as Heart Month in the State of Georgia.

In issuing the proclamation, the governor cited the state's "outstanding heart disease control program" and urged the "greatest support possible" for the annual fund drive.

Governor Vandiver presented the proclamation to Howard Southerland, 13, eighth grade student at College Park High School, in a special ceremony at the state capitol.

In 1958 Howard underwent "open heart" surgery at St. Joseph's Infirmary in Atlanta, and just a year later he won the Atlanta junior tennis championship.

The youth was selected by the Georgia Heart Association as 1960 Heart Ambassador because he is typical of many Georgians who have undergone successful heart surgery, an operation virtually unknown in Georgia 10 years ago.

The Board of Directors of the Georgia Heart Association set the state goal at \$475,000, an increase of \$25,000 over the 1959 goal, according to George H. Brodnax and Carter L. Redd, State Co-Chairmen of the 1960 Heart Fund.

Nearly 18,000 persons died in Georgia of heart and blood vessel diseases during 1958, the governor said. He said this represented nearly 54 per cent of the more than 33,000 deaths in the state from all causes during 1958.

"These startling figures should indicate to all of us the necessity for continuing a vigorous battle against all forms of heart and circulatory diseases," Governor Vandiver said.

"Stroke Rehabilitation" was the educational theme of the 1960 Heart Campaign in Georgia. "Our 40,000 stroke patients represent a tremendous loss in earning power and a resultant family insecurity and economic loss on the local and state levels," the Governor said.

In endorsing the stroke rehabilitation program, the chief executive said:

"Georgia doctors are giving voluntarily of their time and efforts to advise and instruct at stroke clinics sponsored in the state by the Georgia Heart Association.

"At these clinics interested persons are taught rehabilitation in order that they may assist physicians in training stroke victims and their families within the patients' own home."

Governor Vandiver praised the statewide heart clinic system, also staffed by volunteer workers, and urged support of research, education, and community service projects of the Georgia Heart Association.

In his proclamation, the Governor said: "These individuals and groups depend largely on public support and interest for funds with which to carry on this vital research which benefits us all and which will greatly benefit future generations."



heart page

THE EVALUATION OF CARDIACS FOR SURGERY

Ralph A. Huie, Jr., *Atlanta*

WHEN FACED WITH necessary surgery the poorer risk cardiac patient can be helped to tolerate major surgical procedures with careful preoperative medical evaluation. The preoperative evaluation is made through a careful history and physical examination to determine the etiology of the heart disease and the degree to which cardiac function may be decreased. It is always well to remember that acute cardiac conditions may manifest themselves as apparent surgical ones such as the acute abdomen seen in some myocardial infarctions. Such awareness may save them unnecessary surgery.

In rheumatic heart disease of first importance is the presence of active rheumatic fever which would contraindicate any except emergency surgery. Physical findings of rheumatic activity are arthritis, fever, chorea, subcutaneous nodules, erythema marginatum, pericardial friction rub, gallop rhythm, and changing murmurs. In the electrocardiogram prolonged PR interval, ST elevation in limb leads, serial T wave changes, or prolongation of the QT interval are significant. Elevation of the sedimentation rate or a positive C-reactive protein test are confirmatory. Cardiac enlargement or congestive heart failure in rheumatic heart disease under 20 years of age indicates active rheumatic fever. Valvular lesions without active rheumatic fever present a problem de-

pending mainly upon any evidence of decreased cardiac function. Embolic phenomena, splenomegaly, and fever suggest bacterial endocarditis.

In hypertension without decreased cardiac or renal reserve or active cerebral disease there is little more problem than in the nonhypertensive patient. In the elderly hypertensive the cardiac reserve may be hard to evaluate.

A history of substernal discomfort described as heaviness, burning, tightness, aching, pressure, or other sensations especially when brought on with exertion, excitement, or after meals, should be considered significant of coronary artery disease. Angina, when present, should be brought into its most optimal state before surgery. Angina decubitus should postpone any but the most urgent surgery. Patients with recent myocardial infarctions should be stable for at least six weeks, preferably three months after infarction before elective procedures.

Sinus tachycardia may be the result of fever, anemia, anxiety, less significant disorders, or thromboembolic disease. Occasional ventricular premature contractions may be of no significance but when of recent onset and arising from multiple foci are significant. Atrial fibrillation or paroxysmal arrhythmia suggest evaluation of thyroid function. Atrial fibrillation necessitates preoperative digitalization. Minor

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

degrees of A-V block present no problem. Complete A-V block detected clinically as a slow rate, usually under 40 beats per minute, with a changing intensity of the first heart sound at the apex, is very serious. It is frequently associated with a history of syncope. Complete bundle branch block in the absence of signs of decreased cardiac reserve or recent myocardial damage is not a contra-indication to elective surgery.

In cor pulmonale relief of pulmonary infections as well as evaluation and institution of therapy with expectorants and broncho-dilators is important.

In all heart disease a history of exertional dyspnea, orthopnea, paroxysmal nocturnal dyspnea, and salt and water retention manifest by weight gain or pedal edema must be sought for to indicate cardiac reserve. Completeness of digitalization, adequacy of salt restriction, and need of diuretics must be evaluated. Asthma in a cardiac, especially occurring at

night, may represent nocturnal dyspnea of heart failure.

Laboratory data include a routine urinalysis, blood count, chest x-ray or fluoroscopy, electrocardiogram, and indicated blood chemistries. The electrocardiogram is not the main factor in deciding whether a patient needs digitalis but in clarifying the significance of chest pain, old or recent myocardial damage, arrhythmia, and in detecting the activity of rheumatic fever.

Notations should be made of medications, especially the corticoids, anticoagulants, anti-hypertensives, and tranquilizers, as these may affect the patient's prognosis.

Of most importance is the fact that the cardiac patient can best tell us through the description of the degree to which he can carry on his normal or limited activity just how well he will tolerate the anticipated surgery.

MAG INSURANCE PROGRAM TRANSFER

MR. M. D. KRUEGER BROUGHT to the attention of the members of Executive Committee of Council the previous Council action transferring group contracts for the membership on insurance coverage of term life insurance, health and accident insurance, and hospital nurse catastrophic insurance from the Provident Life and Accident Insurance Company to the Life Insurance Company of Georgia. Mr. Krueger then read letters drafted by MAG attorney Francis Shackelford to send to the Provident Life and Accident Insurance notifying them of the transfer. On motion duly made and seconded, it was voted that the letter covering the three group contracts with Provident be sent to Provident Life and Accident Insurance Company as drafted by Mr. Shackelford and further that the letter be published in the *Journal of the Medical Association of Georgia* for the information of the membership. This letter follows:

Mr. Jack Powell
Provident Life & Accident Insurance Company
725 Broad Street
Chattanooga, Tennessee

Re: Policies MG11-10019, MG-10009, GCH-10026,
Insuring Members of The Medical Association
of Georgia

Dear Mr. Powell:

Pursuant to a resolution adopted by the Council of The Medi-

cal Association of Georgia, we wish to give written notice of the termination of the above noted policies at the end of their present terms.

The Life Insurance Policy (MG11-10019) and the Disability Income Policy (MG-10009) will therefore terminate on October 15, 1960. The Major Hospital Policy (GCH-10026) will terminate on August 15, 1960. All of these policies require 60 days notice of termination and this letter can be considered as such notice.

We assume that under the terms of these policies, the termination will be without prejudice to the rights of any member as respects any claim or claims incurred while the policies are in force. We further assume that termination of this policy will not affect the continuation of insurance according to the provision "Continuation of Insurance Because of Total Disability" on the life of any insured member who is totally disabled on the date of termination.

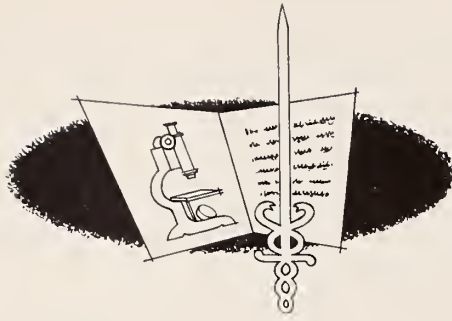
These policies are being replaced by policies written by another insurer. The new policies provide larger amounts of life insurance. In view of the change of carriers, we assume that Policy MGL-10019 provides for no conversion privilege upon termination of the group.

In order to facilitate the change of carriers, and to help see that no loss of coverage occurs, we would greatly appreciate receiving from you a list of the members of The Medical Association of Georgia now covered under each of the three policies. We are, therefore, requesting that such lists be sent to us.

In behalf of the Medical Association, I certainly appreciate your cooperation over the past years.

Cordially yours,

Luther Wolff, M.D.
President



cancer page

THREE CANCER SYMPOSIA SLATED FOR APRIL

A. H. Letton, M.D., *Atlanta*

THE AMERICAN CANCER SOCIETY'S Georgia Division has arranged for three medical symposia on cancer to be conducted for Georgia physicians during April. They will be held in Valdosta, Rome, and Augusta.

These symposia are part of the Georgia Division's Professional Education Program, which is aimed at assisting the state's physicians in keeping abreast of the latest developments in cancer research, diagnosis, and treatment.

The Valdosta symposium will be held Friday, April 8, in conjunction with the meeting of the Eighth District Medical Society. One of the program participants will be Dr. Robert L. Brown of Emory University in Atlanta, whose topic will be "Tumors of the Neck." Physicians throughout South Georgia are invited to attend this symposium. Other speakers are not yet definite.

The symposium in Rome will be conducted on Wednesday April 13, in conjunction with the meeting of the Seventh District Medical Society. Participants will include Dr. Garnet W. Ault from The Proctology Clinic in Washington, D.C. speaking on "Carcinoma of the Colon." "Cancer of the Lung" will be the subject of Dr. Richard King of Atlanta. Dr. Eugene P. Pendergrass from the University of Pennsylvania's School of Medicine in Philadelphia will speak on the "Use of X-ray in Malignant Diseases." Dr. Pendergrass is immediate past president of the American Cancer Society. Dr. Perry Hudson of New York will discuss "Prostatic Cancer."

The third symposium will be held April 15, at the Medical College of Georgia in Augusta. Participants will include Dr. Ault, Dr. Pendergrass, and Dr. Edward F. Lewison of Johns Hopkins Hospital in Baltimore, Md., whose subject will be "Cancer of the Breast." Members of the Richmond County Medical Association and all physicians from East Georgia and West Carolina are invited. We hope all physicians in these sections of the state will take advantage of this opportunity to share the knowledge of these men.

Notes

Other services available to Georgia physicians through the American Cancer Society's Georgia Division include:

- (1) Upon request, free subscription to "CA", a bi-monthly bulletin on cancer progress.
- (2) The loan of medical films and kinescopes on cancer diagnosis and treatment.
- (3) Free booklets and brochures on the diagnosis and treatment of cancer.
- (4) The loan of graphic exhibits and displays on the cancer problem.
- (5) Non-medical leaflets, brochures, films, and exhibits available to explain the cancer problem and its warning signs to the general public.

For additional information about any of these services, write to American Cancer Society, Georgia Division, 2025 Peachtree Road, N.E. Atlanta 9, Ga.

Approved by Professional Committee, Georgia Division, ACS.

current clinical concepts

Inclusion-bearing Cells in Urine During Viral Infections

THE PRESENCE OF inclusion-bearing cells in the urine in large numbers is very characteristic of rubella but is not pathognomonic of the disease. During a recent epidemic of viral infection in the Cleveland area similar cells were found in the urine from children with rubella, varicella, mumps, herpangina, and less frequently in apparently normal children.

Bolande, R. P., *Ped.* 24:7 (July) 1959.

Serum Lactic Dehydrogenase and Serum Transaminase in Human Leukemia

THE AUTHORS PERFORMED estimations of serum lactic dehydrogenase (SLD) and serum glutamic oxalacetic transaminase (SGO-T) concentrations in patients with acute and chronic leukemia. Elevations of SLD appeared in the majority of all these patients and appeared to be significantly greater in the chronic myelocytic leukemias. There is a disappointing lack of over-all correlation between serial SLD levels and leukemic activity.

SGO-T levels greater than 100 units were seen in about 10 per cent of the patients. It is suggested from these studies that a SGO-T level of more than 100 units in a patient with leukemia associated with jaundice or other evidence of hepatic involvement would suggest a viral or toxic type of hepatitis. The presence of a normal or slightly elevated SGO-T level would be compatible with leukemic infiltration of the liver.

Magill, G. B.; Wroblewski, F., and La Due, J. S., *Blood* 14:870-881 (July) 1959.

Thoracoscopy—A Useful Aid in Chronic Pleural Effusion

NOT INFREQUENTLY THE differential diagnosis of chronic pleural effusion proves difficult. Careful ex-

amination of the sputum and the bronchial tree, as well as ordinary radiographic and bronchographic studies, may not establish the diagnosis. Blind pleural biopsy, or open thoracotomy with inspection and biopsy have been recommended as diagnostic aids. In our experience we have found most useful the employment of the thoracoscope. With the aid of this instrument careful inspection of both the visceral and parietal pleura may be carried out and biopsies of selected areas of the pleura may be obtained without difficulty. The technique has been employed in over 25 patients with very gratifying results.

DeCamp, Paul T., M.D. and Hatch, Hurst B., M.D., New Orleans, La., at the Southern Thoracic Surgical Assn. at Edgewater Park, Miss., Nov. 19-21, 1959.

Staphylococcic Pneumonia and Empyema in Infants and Children

NINE CASES OF staphylococcic pneumonia in infants and children are presented. In six of the cases there was extra-pulmonary staphylococcic infection. Otitis media occurred in two children, ages 12 and two years, respectively, and in each of these the organism showed evidence of resistance to antibiotics. Four cases required intercostal tube drainage for pyopneumothorax secondary to rupture of pneumatoceles. The importance of X-ray examinations in establishing an early diagnosis and the early roentgenologic signs are stressed. It is felt that staphylococcic pneumonia carried a very low mortality rate if recognized promptly so that the pleural complications can be anticipated and promptly treated if they occur. Empyemas are surgical emergencies in infants.

Gragg, Wilford H., Jr., M.D. and Cara, D. J., M.D., Memphis, Tenn., at the Southern Thoracic Surgical Assn. at Edgewater Park, Miss., Nov. 19-21, 1959.

Clinical Use of Pyrazenamido for Excisional Therapy in the Poor Risk Tuberculous Patient

PYRAZENAMIDE HAS BEEN used for short term coverage in a group of approximately 36 patients who have been subjected to long term conventional therapy. Many of these patients have had various types of previous therapy in addition to from two to five years of antimicrobial therapy. These studies have been carefully controlled to detect toxic manifestations from the drug. Minimal variations in hepatic function have been detected but have not seemed of sufficient magnitude to interrupt therapy. Major post-operative complications have been extremely rare.

Stephenson, Sam E., Jr., M.D.; Hubbard, W. W., M.D., and McCracken, R. L., M.D., at the Southern Thoracic Surgical Assn. at Edgewater Park, Miss., Nov. 19-21, 1959.

Bronchial Adenoma: Modern Variations on an Old Theme

WITH THE OUTLOOK so bleak for the average case of bronchial carcinoma, it is refreshing to re-

when
sulfa
is your
plan of
therapy..



pharmacologically and clinically the outstanding

Rapid peak attainment — for early control —
KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours^{1,2} . . . or approximately one-half the time of other once-a-day sulfas.² Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control —
More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.² Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.³

Extremely low toxicity⁴ . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies⁵ in 223 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation⁴ in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product⁶ obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, *E. coli*, *A. aerogenes*, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: *Antibiotic Med. & Clin. Ther.* 3:378, (Nov.) 1956. 2. Boger, W. P.: *Antibiotics Annual* 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: *Antibiotic Med. & Clin. Ther.* 5:604 (Oct.) 1958. 4. Vinnicombe, J.: *Ibid.* 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: *U. S. Armed Forces M. J.* 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: *Ann. New York Acad. Sc.* 60:457 (Oct.) 1957.



Legal page

MEDICAL SOCIETIES AND POLITICS

John L. Moore, Jr., *Atlanta*

THE YEAR 1960 promises to be a year in which doctors of medicine and their county, state and national associations will be, and ought to be, interested in the passage or defeat of Congressional legislation and in the candidacy of particular men for offices in the Federal Government.

Of practical importance to county societies and The M.A.G. are the laws known as the Hatch Act of 1939 and the Federal Corrupt Practices Act of 1925 (18 U.S.C.A., Sections 591, et. seq.). The most pertinent language is in 18 U.S.C.A. § 610, which describes a crime punishable by severe fine and imprisonment of a corporation and its officers who wilfully participate:

"It is unlawful . . . for any *corporation* whatever, or any labor organization to make a contribution or expenditure in connection with any election at which Presidential or Vice Presidential electors or a Senator or Representative in, or a Delegate or Resident Commissioner to Congress are to be voted for, or in connection with any primary election or political convention or caucus held to select candidates for any of the foregoing offices . . ."

[Emphasis supplied]

Notice first that this Section only applies to *corporations*. The Medical Association of Georgia and many county societies are corporations but societies not incorporated may disregard § 610 with impunity.

If § 610 were read literally it would practically

proscribe any expression of opinion by an incorporated medical society at any time near a Federal political convention, caucus or election. However, the Supreme Court of the United States has somewhat limited the broad interpretation of the section, confusing though the decisions are. For safety's sake, a wide berth should be allowed this section.

Philip Murray, President of the C.I.O., wrote an editorial in the weekly *C.I.O. News* urging members to vote against the Republican nominee and for the Democratic nominee in Maryland's Third Congressional District. Murray and the C.I.O. were indicted under Section 610. The Lower Court dismissed the indictment on the theory that Section 610 was an unconstitutional abridgment of the First Amendment. The Supreme Court, by a 5-4 vote, agreed but on a different ground. The majority said that Section 610 must be construed so as to uphold its constitutionality. A construction that the C.I.O. had violated the Act would make it unconstitutional because any group ought to be able to express its political views. Therefore, Section 610 did not cover this activity. *U.S. v. C.I.O.*, 335 U.S. 106 (1948).

However, in *U.S. v. United Auto, etc. Workers*, 352 U.S. 567 (1957) the Supreme Court said that the union's use of dues money to sponsor a television broadcast designed to support certain candidates for Congress would violate Section 610. On the other hand, in *U.S. v. Painters Local Union No.*

Prepared at the request of the Medical Association of Georgia. Mr. Moore is an associate in the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.

481, 172 F. 2d 854 (1949) a lower court held that the section was not violated by a small labor union which paid \$111.14 for a political advertisement in a daily newspaper of general circulation and \$32.50 for a political radio broadcast. The union was opposing the nomination for President of one Republican and reelection of six incumbent Congressmen. The Court thought the payments "trivial."

In the light of these cases incorporated medical societies *should not*:

- (1) Contribute society funds to any candidate or party in a Federal election, whether directly or through a third person or a "committee";
- (2) Donate any funds for or prepare any campaign literature for distribution in support of or against any Federal candidate;

- (3) Use any society funds to buy newspaper space or radio or television time for or against any Federal candidate;
 - (4) Use society funds to solicit persons to help candidacies for Federal offices or to contribute in any way to pay for such services.
- Incorporated medical societies are free, however, to make their general political beliefs known to the public and to urge the public to vote. Through their regular professional publications, medical societies can inform their own members as to the desirability of voting, the voting records of candidates and what the views of the Association are, whether or not critical, about particular Federal candidates.
- It is obvious that the law is very technical and the views expressed in this article very general. Any medical society, before engaging in any activity in this area, should consult its attorneys.

EASTER SEALS

EASTER IS STILL MANY weeks away, but going into the mails this month are 1960 Easter Seals. We hope you will watch for them. They are messengers of hope for crippled children and adults in all cities, in Georgia and in the nation.

The seals, in a real sense, are personal Easter greetings awaiting responses that require understanding and a measure of sacrifice.

Through it all, the Georgia Society for Crippled Children and Adults carries out its program of services for hundreds of physically handicapped Georgians each year.

The campaign is indeed a worthy one. Through the spiritual and material giving it entails, it is entirely in keeping with the true significance of the Easter season.

FINANCIAL AID TO MEDICAL STUDENTS

ONE BASIC APPROACH to the understanding of medical students' financial standing is to examine the facts concerning student indebtedness. Some recent findings concerning the experience of the 1959 graduating class is summarized below.

Medical Student Finances

- 1. Number of Students in 1959 Graduating Class 6,799*
- 2. Average Cost of 4 Years of Medical School to the Students in the 1959 Graduating Class \$11,642
- 3. Estimated Total Cost of 4 Years of Medical School to All Students of 1959 Graduating Class \$80,000,000
- 4. Per cent of Students in 1959 Graduating Class Who Have Liabilities From Any Source 52%

- 5. Number of Students in 1959 Graduating Class Who Have Loan Liabilities Directly Related to Their Medical Education and Whose Total Liabilities are Greater Than Their Total Assets (Students Who Need Financial Assistance). 2,257
- 6. Per cent of Above Type of Students in 1959 Graduating Class 33%
- 7. Total Liabilities of This Group of Students \$12,450,786
- 8. Total Assets of This Group of Students \$ 2,841,716
- 9. Total Indebtedness (Net Liability) of This Group of Students \$ 9,609,070
- 10. Average Indebtedness (Net Liability) Per Student of This Group of Students \$4,258

*Based on report from medical school deans at time of data collection for the study on medical student finances.



mental health page

THE AMBULATORY SCHIZOPHRENIC PATIENT

Carl A. Whitaker, M.D., *Atlanta*

THIS DISCUSSION IS INTENDED to apply to the management of ambulatory schizophrenic patients in the general practice setting. No effort is made to discuss psychotherapy as such or to indicate methods for trying to resolve the illness. Instead it is assumed that a certain per cent of patients can be helped to adjust to the social structure by the usual contact with their physician.

Every physician's patient load includes a certain number of individuals who are eccentric, bizarre, or frankly peculiar and who by virtue of this become a management problem. The term schizophrenic is usually reserved for those patients who are frankly psychotic. However, some patients who are seriously ill conceal this from their friends and their doctor. Frequently the doctor suspects it and out of kindness does not push for clinical evidence. There is little reason to force the patient to reveal his symptoms but nothing is lost if he decides to confide in his doctor. The less disturbed patients are usually "compensated" psychotics. They may show evidence of suspiciousness (paranoid-like) or of severe isolation (catatonic-like) or silly bizarreness (hebephrenic-like) or they may be misdiagnosed feeble-minded (simple). Occasionally any one of these may begin to decompensate either in the sense of becoming pre-occupied with his body and its functioning or in becoming grossly disturbed in his relationship to the people around him. A solid relationship with his

doctor may then enable him to re-adapt to his community. The downhill road of the sickness may continue or may be slowed or even arrested by the family physician. Ordinarily these patients become better adjusted in later years. This is often associated with a gradually decreasing interest in life and a settling down into a very routine existence.

The Relationship to the Doctor

To maintain a consistent relationship with this type of patient requires a certain clarity about what the doctor is going to offer. The pattern should be planned so that it is available over a period of years. It is not wise for the doctor to give a great deal of time and consideration over a short period, only to become discouraged and withdraw entirely. The patient needs to know that the doctor respects his own time and can only offer a few minutes and at specific time intervals, e.g., 15 minutes at a time, once a week or once every two or three weeks. He also should be told that when the doctor's schedule makes it impossible for him to fulfill an appointment, another appointment can be established with the nurse.

The patient's confidence must never be violated. When the doctor gives him 15 minutes he should not take five minutes "back" to make a telephone call. The doctor should not allow the patient to borrow time from other patients or demand emer-

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

gency help if there is no emergency. Ordinarily the patient benefits most from a kindly "father" who not only has some personal feeling for the patient but who is willing to point out the whirlpools the patient may run into or is even now edging toward. It is equally important that the doctor be certain to stay out of the "leaky boat" itself. It is safe to assume that within himself the patient is deeply resentful of almost everyone in his intimate family but that at the same time he has grown up to sacrifice his very life for them.

The Doctor's Relationship to the Family

Although the family of this kind of patient is extremely solicitous and sincerely so, it is also true that they almost routinely work behind the patient's back and it is almost impossible to teach them to do otherwise. Inside themselves they have lost all hope for the patient's maturity, (but they dare not admit that, and therefore frequently push to get help for him). Because of this ambivalent (two-sided) feeling it is important that the doctor maintain his professional role and not allow himself to be "sucked into" giving advice behind the patient's back.

If he must sign commitment papers for the patient, this should be done on the basis of either the patient's need and readiness for treatment or the obvious necessity to get the patient out of the community. If action is taken on the basis of the family's demand only, that is with no pathological behavior which is upsetting the community, it is extremely important that there be a family conference with the patient present. It is important for the doctor to try to stay out of any struggle between the patient or the patient's family and the community. This part

of the problem belongs to the family. Misbehavior is not a medical problem. The family often try to use medical help as a substitute for legal help or family togetherness but it is a mistake to get into this and it will lead to further trouble of a similar nature.

Every physician regardless of his clinical specialty has a handful (or two or three) of these ambulatory schizophrenic patients in his practice. There are not enough psychiatrists available in the country to "relieve" their colleagues of this type of patient in the foreseeable future. Nor need this shortage seem hopeless. The local medical doctor is in an excellent position to handle these cases adequately. One of the secrets in dealing with these people is to recognize the illness and then structure a plan with the patient that fits the doctor's schedule. Let the patient know that he may want to see the doctor more frequently than the "schedule" calls for but that this plan must be followed. Outline with the patient that he suffers from a chronic illness and that treatment is a long term project—then the doctor should stick to the structured plan. The patient will "test" the doctor—the doctor should feel free to be quite firm about no "calls" between appointments, leaving when time is up, etc. Over a period of time these patients show definite improvement and are among the most grateful of patients. The physician who has some efficacy in handling this type of patient will find the usual neurotic much more tolerable than heretofore and will lose the chronic guilt of having to "shoo away the crock." These patients respect the doctor who respects his own limited time and who tells them when they are annoying. These patients live in a world of shadows and hatred behind faint smiles. Having successfully managed the first ambulatory schizophrenic, the second and third patients become easier.

VENEREAL DISEASE

SINCE THE INTRODUCTION of the antibiotics, Health Information Foundation points out, the over-all death rate from syphilis has dropped from 12 persons per 100,000 population in 1943 to 2.2 in 1958. Nevertheless, an estimated million persons in this country still have the disease.

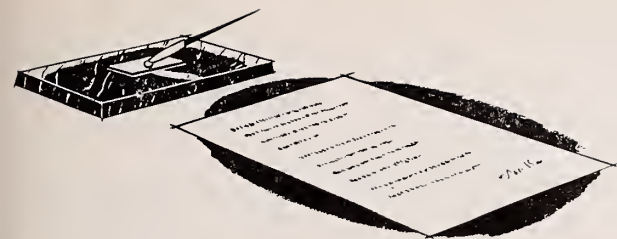
Although the incidence of venereal disease is still high, 30 infants in this country died from congenital syphilis last year, while 3,460 would have died if the 1930 rate had continued.

Despite sharp drops in the incidence of venereal dis-

ease since the development of antibiotics, an estimated 60,000 cases of syphilis and 1,000,000 of gonorrhea are still acquired each year. "Complete elimination of these diseases, is at this point far from achieved."

The rate of first admissions to mental hospitals for paresis, a complication of syphilis, has dropped from 4.7 per 100,000 population to 0.5 since the antibiotics were introduced. In spite of such figures, according to Health Information Foundation, the problems of venereal disease in the U. S. are far from solved, chiefly because of public apathy and ignorance.

abstracts by georgia authors



McDonald, Harold P.; Upchurch, Wilborn E., and Artime, Manuel E., St. Joseph's Infirmary, Atlanta 3, Georgia, "Visualization of Vesical Masses by Excretory Urography," Am. Pract. 10:2140-2142 (Dec) 1959.

For understandable reasons the major emphasis in excretory urography is placed upon the pattern in the upper urinary tract. Nevertheless, much valuable information can be gleaned by visualization of the bladder neck, especially in women where unanticipated obstruction may be shown.

Excretory urograms are made with the idea of maximum visualization of the entire urinary drainage system. As the bladder begins to fill during the progress of the urograms, films are made up to 45 minutes or until a satisfactory cystogram is obtained. If prostatic calculi are suspected, the x-ray tube is slanted to eliminate overlay of the shadow of the pubic bone. Oblique films are taken at times to demonstrate more clearly a suspected lesion in the bladder wall. The enlarged prostate in the males and the masses of the vesical neck in woman and children are frequently well visualized by this means. Attention is called to this important diagnostic measure and representative illustrations are included.

Warkentin, John; Whitaker, Carl A., and Malone, Thomas P., 2905 Peachtree Road, N.E., Atlanta 5, Georgia, "Social Origins of Delusions," South. M.J. 52:1418-1420 (Nov) 1959.

The authors have observed repeatedly that delusional thinking is not merely a symptom of illness in the patient. It is sometimes a specific self-reparative effort. The delusion can construct for the patient a more tolerable view of life than he can see in reality. Thus, a delusion can help to control his anxiety. For example, the patient who has the delusion that he is a "queer" may actually be moving in the direction of recognizing his sexual immaturity; at the same time, he feels more secure because he himself labels such thoughts "delusional." A further interesting fact, already noted by Freud in 1938, is that a delusion may have in it a historically correct "kernel of truth." The authors have extended this idea, and outlined case fragments where the delusional thinking of the patient had a basis in fact in a similar way as dreams do. As is true of dreams, the delusions may resemble wishful thinking, and may be closely connected to actual life

experiences. A careful interpretation and evaluation of delusional thinking is, therefore, a valuable procedure for the psychotherapist in helping the patient to find a more satisfactory personality integration.

Skandalakis, John E.; Vincenzi, Rosina; Rand, Edgar O'Conner, and Poer, David Henry, 1968 Peachtree Road, N.E., Atlanta 9, Georgia, "Extra-Adrenal Retroperitoneal 'Non-functioning,' Paraganglioma," South. M. J. 52:1368-1370 (Nov) 1959.

A case is reported of a 63 year old man with an extra-adrenal retroperitoneal paraganglioma. It is significant that the diagnosis was not made prior to operation, during surgery, or in the autopsy room. This patient never presented the clinical picture of pheochromocytoma. The only complaint and finding was an epigastric mass of two years duration. During surgery the patient's blood pressure fluctuated markedly, ranging from shock to hypertensive levels. In an effort to determine the origin as well as the operability of the tumor in the operating room, the tumor was manipulated excessively. The diagnosis at the time was retroperitoneal sarcoma. Death occurred six hours later and autopsy revealed a retroperitoneal tumor which was heavily fixed to several organs. The diagnosis of extra-adrenal retroperitoneal paraganglioma was made after microscopic studies.

The authors presented this case to emphasize the care one should take in handling a retroperitoneal tumor even though no clinical evidence of hormonal activity is present. The literature was reviewed and the nature of this rare tumor was discussed.

Petrie, Lester M., Preventable Disease Service, Georgia Department of Public Health, Atlanta 3, Georgia, "To Each His Own—A State Occupational Health Program," Am. J. P. Health 49:1658-63 (Dec) 1959.

Occupational health is the health of employed people as it relates to their work and their working environment. A state-wide program must reach all employed people in private enterprise, government, or schools. Its primary purpose is educational—to teach every individual his own inescapable responsibilities for his own health, the limitations of his own resources, and the available community resources to help him; likewise, to teach every employer his organizational health responsibili-

ties, limitations, and community resources. Community resources include private medical care, public health, and rehabilitation agencies. To reach every individual, sick call for the few should not be permitted to crowd out health service for the many. A battery of health tests is effective "bait" to attract the many to accept individualized health counseling. Rewards to each individual are his own health and high standards of living; rewards to the community include increased production—the healthier our people become, the greater will be our prosperity.

Wood, J. Edwin, Medical College of Georgia, Augusta, Georgia, "A Hydrostatic Pressure Stocking for the Treatment of Ulcers Due to Chronic Venous Insufficiency," Circulation 22:1043-1048 (Dec) 1959.

A device is described that reflects counterpressure onto the surface of the leg in such a way that the pressure is equivalent to that of a vertical column of water between any point on the leg and the level of the right atrium regardless of the position of the patient. Ten patients with ulcer of the skin of the leg due to chronic venous insufficiency used the hydrostatic pressure stocking as a sole means of therapy while pursuing their usual daily activities. All of the ulcers healed completely with this treatment. The rate of healing was as rapid as might have been expected with complete bed rest and elevation of the extremity. This hydrostatic pressure stocking appears to be of special value to patients who have chronic venous insufficiency with repeated formation of ulcers after all forms of surgical therapy have been exhausted. The results of these studies suggest that local edema of the tissues is the primary cause of the ulcers but decreased blood flow and sudden rises of local venous pressure cannot be ruled out as contributing factors.

Weiner, Daniel and Brooke, M. M., C.D.C., U. S. Department of Health, Education, and Welfare, Atlanta, Georgia, "Investigation of Parasitic Infections in the Central Area of Philadelphia," Am. J. Trop. Med. 8:624-629 (Nov) 1959.

In order to obtain data on the parasitological situation in Philadelphia, resulting from an increase in Puerto Rican residents, an intestinal parasite survey of school children and a housing survey were conducted in the fall of 1957.

ABSTRACTS / Continued

Of 395 stool specimens examined, 42.3 per cent were from Puerto Rican children and 58.7 per cent from non-Puerto Rican children (White, Negro, Mongolian). The examinations revealed 83.2 per cent of the Puerto Rican, 51 per cent of the Negro, and 30.2 per cent of the White children infected with parasites.

Fifteen different parasites were identified. The highest prevalence of any single species was for *T. trichiura* (67.7 per cent in the Puerto Rican children). Excluding *E. vermicularis*, for which specific examinations were not performed, the prevalence ratio for all helminths were higher in the Puerto Rican children. Although generally true for the protozoa, several of the species had the highest prevalence in the non-Puerto Rican group (e.g. 8.2 per cent for *E. Hystolytica*). The prevalence of *D. fragilis* (24.5 per cent) for the Negro children was 4-5 times higher than for the other groups.

The housing quality survey revealed that the dwellings in the central area of Philadelphia are over-crowded and deficient in toilet and bathing facilities, which in all likelihood must facilitate transmission by direct contact.

Quattlebaum, Julian K.; Upson, E. Thomas, and Neville, R. L., 24 W. Gaston Street, Savannah, Georgia, "Stroke Associated with Elongation and Kinking of the Internal Carotid Artery," *Ann. Surg.* 150:824-832 (Nov) 1959.

Numerous authors have previously published on various surgical procedures to relieve atheromatous obstructions of the cervical portion of the internal carotid artery causing symptoms of cerebrovascular insufficiency. Three cases are herein presented in which transient hemiparesis has been found to be associated with elongation of the carotid artery to the point of kinking of the internal carotid. In each there was either none or insignificant associated atherosclerosis. In the two cases in which bilateral arteriograms were

carried out, there was bilateral elongation and tortuosity, suggesting that co-incident bilateral kinking of some degree may be necessary to produce symptoms in the absence of atherosclerotic interference with collateral flow to the brain. One patient was treated by segmental resection of the common carotid artery, and two by resection of the carotid bifurcation, relieving the tortuosity in each instance. None has had further symptoms of cerebrovascular insufficiency. Preoperative evaluation of collateral cerebral blood flow by a Matas test and then exploration under local anesthesia with a test period of occlusion to further assess this point is recommended. If inadequate collateral flow is demonstrated, then general anesthesia with hypothermia is utilized for the arterial resection.

Fair, John R., Medical College of Georgia, Augusta, Georgia, "Congenital Toxoplasmosis: IV Case Finding Using the Skin Test and Ophthalmoscope in State Schools for Mentally Retarded Children," *Am. J. Ophthalmol.* 48:813-819 (Dec) 1959.

A total of 1,700 inmates in state schools for mentally retarded children were screened for the central chorioretinitis of congenital toxoplasmosis, using the skin test and ophthalmoscope. Eight probable and two possible cases were found. All gave positive skin and Sabin-Feldman dye tests for toxoplasmosis. The clinical and serologic aspects of the problem are discussed.

Freeman, Thomas R., and Lippitt, William H., 200 E. 31st Street, Savannah, Georgia, "Carotid Artery Syndrome: Results of Endarterectomy in 26 Cases," *Ann. Surg.* 150:1041-1045 (Dec) 1959.

In 22 of 44 patients suffering cerebral vascular accident the carotid artery syndrome was present. In four the disease was bilateral.

Twenty-six operations were performed on the 22 patients; carotid endarterectomy was the procedure used in all. In three re-exploration was necessary because of complications.

The patients are classified into four categories on the basis of history and

physical findings at the time of first examination. Since the degree of obstruction of the artery was not related to the severity of the "stroke," no pathologic classification is attempted.

The results of endarterectomy in this series are presented in tabular form and are discussed.

Since the preparation of the manuscript, six-and 12-month follow up arteriography has shown no new defects in the arteries operated on, and there has been no recurrence of symptoms. This series now includes 81 primary operations in 67 patients (14 bilateral) with relief of symptoms in 90 per cent.

Humphries, Arthur L., Jr., M.D. Medical College of Georgia, Augusta, Georgia, "Kidney Homotransplantation in Castrated and Noncastrated Male Goats," *Am. Surgeon* 25:369-373 (June) 1959.

This study was undertaken to determine what effect, if any, the absence of the male gonad has on the fate of homotransplanted kidneys. Previous experiments had shown that homotransplanted kidneys in castrated male goats secreted urine for a mean of 15.6 days, a longer period than has been reported for any animal other than man.

In a total of 26 experiments, kidneys were transplanted from normal bucks to normal bucks, castrated males to normal bucks, and normal bucks to castrated males for comparison with those from castrated males to castrated males, to determine whether there is any difference in the fate of the homotransplanted kidneys among these four combination groups.

The results were essentially the same, in every respect including total time of urine secretion and histopathology, for the four donor-host combination groups studied. The histopathology was somewhat unique, however; the inflammatory changes in the arteries and the atrophic changes in the tubules were less advanced in these homotransplanted kidneys in goats than in those reported by others in dog and man.

It was concluded that the absence of the male gonad did not influence the fate of renal homotransplants.

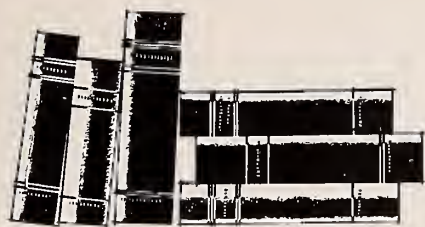
DOCTORS' HOBBY REACHES AROUND WORLD

MANY PHYSICIANS MAKE world-wide acquaintances through their hobbies as amateur radio operators. They also have opportunities to discuss medical problems and share knowledge with other physicians.

In some areas, physicians who are "hams" have joined to form panels of consultants available to any

part of the world needing medical advice. They also assist in disasters.

Herschel U. Martin, Dalton; George W. Brown, Griffin, and Charles McArthur, Cordele are among the doctors in Georgia that enjoy this hobby as amateur radio operators.



physician's bookshelf

REVIEWS

Hyman, Albert Salisbury, M.D., **THE ACUTE MEDICAL SYNDROMES AND EMERGENCIES**, Landsberger Medical Books, Inc., New York, N. Y., 1959, 442 pp., \$8.75.

THIS CONCISE BOOK is directed by its editor toward the practical discussion of the important acute medical problems that tend to arise in an active medical or general practice. It is presented in six sections: Heart and Chest Pain, The Gastrointestinal Emergencies, The Pulmonary Emergencies, Diabetic Emergencies, The Renal Crises, and The Barbiturate Intoxication. Each section is written by the editor or one of his collaborators in a very readable form. The subjects are discussed practically with almost all attention being given to the symptomatology, differential diagnoses, and treatment of the material. It is not meant to be a reference work, but one that can be read leisurely and even for pleasure. Many useful points in history taking, particularly as applied to prompt recognition of the acute disorder is emphasized. Little attention is given to theoretical or laboratory aspects of the problems. Each section devotes full discussion to treatment with chemical and proprietary names of drugs, manufacturer's name, and dosages suggested. Newer drugs are mentioned but the older and practical ones are emphasized.

In addition, as the book is so easy to read and is especially written for the practicing physician, many valuable and useful tips are dropped here and there throughout the book: such points as how to prevent nitroglycerin from losing its potency or how and when best to transport a patient with suspected myocardial infarction to the hospital in a private auto are clearly discussed.

All in all, the editor has offered a practical, easy-to-read book on medical emergencies for the busy practitioner of medicine.

J. H. Hilsman, M.D.

Smith, Edward B., M.D.; Beamer, Parker R., Ph.D., M.D.; Vellios Frank, M.D.; and Schulz, Dale M., M.D., **PRINCIPLES OF HUMAN PATHOLOGY**, Oxford University Press, New York, N. Y., 1959, 1123 pp., \$15.00.

THIS IS A BOOK of general pathology consisting of 1,223 pages divided into 69 Chapters, prepared by four well

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

qualified authors. It is written primarily for medical students as an aid in the course of Pathology.

The scope of the material is broad and allows for brief coverage of individual diseases and organs. It is extensively indexed and contains references to the more recent articles in the medical literature.

The text is well written and easily readable. There are separate chapters on diseases of the placenta and newborn not usually found in general pathology texts.

It is regrettable that some of the reproductions of the photographs could not be improved. Certainly this book easily fulfills the purpose for which it was written as stated in the preface, i.e., to emphasize important general facts and theories of pathology.

John T. Godwin, M.D.

Clark, William B., M.D., F.A.C.S., **SYMPOSIUM OF GLAUCOMA**, The C. V. Mosby Co., St. Louis, Mo., 1959, 314 pp., \$13.50.

GLAUCOMA IS THE SUBJECT of the sixth annual session of the New Orleans Academy of Ophthalmology, the proceedings of which are recorded in this volume. The material presented is a symposium of the present day knowledge of the histology, pathology, biochemistry, diagnosis, and treatment of glaucoma. The contributors are among the most prominent in the glaucoma field. All phases of the subject are covered in a concise but complete manner. Consideration of diagnosis and treatment is preceded by chapters on anatomy, pathology, biochemistry, and physiology of aqueous production and flow, tonography, and a classification of glaucoma. The medical and surgical management of the various types of glaucoma is covered in detail. Sixty-five pages of round table discussion supplement the formal presentations. Information presented is well documented with reference to the pertinent ophthalmic literature. Recommended especially for students and practitioners of ophthalmology.

John R. Fair, M.D.

Mozes, Eugene B., M.D., **LIVING BEYOND YOUR HEART ATTACK**, Prentice-Hall, Inc., Englewood, N. J., 1959, 212 pp., \$3.50.

THIS IS A COMPREHENSIVE and well-written treatise designed, as the title implies, to bolster the morale of the patient with coronary artery disease. It can be read with profit by the patient of above average intelligence. The reviewer is of the firm opinion that this book, and others of similar type, in no way relieve the attending physician of his responsibility to take the time and effort to explain in a few words all the really necessary in-

PHYSICIAN'S BOOKSHELF / Continued

formation contained in this publication. It must also be remembered that in many patients with coronary artery disease it is necessary to emphasize the seriousness of the situation in order to get proper patient cooperation. In sum, this book is suitable for only a select few coronary artery patients.

Louis K. Levy, M.D.

Hardy, James D., M.D.; Griffin, James C., Jr., M.D.; and Rodriguez, Jorge A., M.D., BIOPSY MANUAL, W. B. Saunders Co., Philadelphia, Pa., 1959, 150 pp., \$6.50.

THIS IS A MANUAL of 150 pages and 12 chapters which discuss general features of biopsy procedures, instruments, fixatives, and the application of biopsy to various organs.

There are many important suggestions in this book which, if followed, would be of great value to the patient, such as proper methods of removal, handling, and fixation of tissues.

This book is rather loosely written with reference to material included and use of words such as malignancy, pathology, and occasional phrases such as "establish positive malignancy."

Another example of this is in the preparation of bone marrow aspirates in which it is stated that the "marrow" is expressed onto the microscopic slides." Only small quantities of marrow should be aspirated (2-3 cc.) and the slide or cover-slip preparation should be spread quickly, deftly, and properly otherwise the entire procedure is valueless.

The use of the Silverman needle in bone marrow studies is not covered. This may in many patients obviate an incisional biopsy.

Aspiration biopsy is not adequately discussed and the only significant reference is to a 1934 article.

The book variously attempts to discuss anatomy, pathology, and treatment sporadically and without consistency in the various areas.

The numerous drawings are very nicely prepared and add very much to the manual.

The stated purpose in writing this manual was to "bring together in a convenient handbook a distillation of our own experiences as well as those of others." It is also stated that "it should be of genuine assistance not only to practicing surgeons and general practitioners but to surgical trainees and medical students as well."

I would agree that the manual fulfils the tenets upon which it was written.

John T. Godwin, M.D.

Merrill, Vinita, ATLAS OF ROENTGENOGRAPHIC POSITIONS, The C. V. Mosby Co., St. Louis, Mo., 1959, 663 pp., index, \$32.50, 2 vols.

"ATLAS OF ROENTGENOGRAPHIC POSITIONS" by Vinita Merrill in two volumes is well and attractively bound, printed on excellent paper, and adequately indexed. This first two of its 20 chapters are devoted to general radiographic information and a brief discussion of general anatomy for the technician. Each of the remaining chapters describes proper positioning of a specific skeletal division or organ system and is prefaced by a well illustrated anatomical description of the pertinent area. Positioning is described and illustrated by excellent photographs and in many instances line drawings of the patient properly positioned in relation to the film, table top, and tube. The resulting roentgenogram is reproduced. Positions are designated anatomically and in many instances by name such as Water's or Law and others less generally known.

The over all result is a comprehensive, concise, and lucid word and picture description of this basic procedure. Volume I contains a glossary of terms pertaining to radiology and Volume II an extensive bibliography. No radiographic technique is included. The author has devoted a great deal of time and effort to the compilation of these volumes which will be of great value to every X-ray technician and consequently to every X-ray department.

GEORGIA SOCIETY FOR CRIPPLED CHILDREN AND ADULTS

CHESTER A. SWINYARD, M.D., Associate Director, Children's Division, New York University Bellevue Medical Center chats informally with some of the physicians who attended the Ninth Annual Meeting of the Georgia Society for Crippled Children and Adults held November 13-14 at Radium Springs, Albany. Reading left to right, Dr. Walter Bloom, Atlanta; Dr. Atwood Freeman, Jr., Albany; Dr. F. James Funk, Jr., Atlanta; Dr. Chester A. Swinyard, guest speaker, and Dr. Ernest Dunlap, Jr., of Atlanta.

Dr. Funk is Acting Medical Director of the Atlanta Easter Seal Treatment Center. Both Drs. Dunlap and Freeman serve as members of Georgia Easter Seal State Medical Advisory Committee and Dr. Bloom is a newly elected Executive Committee board member of the Georgia Society for Crippled Children and Adults.



Mark These Dates on Your Calendar

MAY 1-4, 1960

These are the dates for the

ANNUAL SESSION

of the

**MEDICAL ASSOCIATION
OF GEORGIA**

to be held in

COLUMBUS, GEORGIA

at the

MUNICIPAL AUDITORIUM

It's Annual Session Time Again...

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Medical Association of Georgia 1960 Annual Session

May 1, 2, 3, and 4, 1960, Columbus

A Housing Bureau has been established for your convenience in making your hotel reservations in Columbus for the 1960 ANNUAL SESSION of the Medical Association of Georgia. Comparable room rates are listed. Use the Reservation Blank below. Please specify your first, second, and third choice hotel or motel. All requests for reservations should give: (1) anticipation date and hour of arrival; (2) date and approximate hour of departure; and (3) names and addresses of all persons who will occupy the accommodations. ALL RESERVATIONS MUST BE CLEARED THROUGH THE HOUSING BUREAU. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible. All reservations will be confirmed.

Hotel	Single	For Two Persons	
		Double Bed	Twin Beds
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CANDLELIGHT MOTEL	\$7.00	\$9.00	\$9.00
HOWARD JOHNSON MOTOR LODGE	\$7.00-\$8.00		\$9.00, \$10.00 \$12.00
THE MERRY EL MOTEL	\$7.00	\$8.00	\$9.00, \$10.00
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HOUSING BUREAU
MEDICAL ASSOCIATION OF GEORGIA
The Ralston Hotel
Columbus, Georgia

Please reserve the following accommodations for me for the 1960 Medical Association of Georgia Annual Session:

Hotel or Motel Preference	Kind of Accommodations Desired
1st Choice _____	<input type="checkbox"/> Double Room at \$_____ to \$_____
2nd Choice _____	<input type="checkbox"/> Double Room at \$_____ to \$_____
3rd Choice _____	<input type="checkbox"/> Twin Bedroom at \$_____ to \$_____
	<input type="checkbox"/> Other Type _____
Arrival Date _____	Hour _____ A.M. _____ P.M.
Departure Date _____	Hour _____ A.M. _____ P.M.

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include the names of all persons for whom you are requesting reservation and who will occupy the room(s):

Name of Occupant(s)	Address
_____	_____
_____	_____
_____	_____

Individual Requesting Reservations

Name _____

Address _____

City _____ Zone _____ State _____

If the hotel or motels of your choice are unable to accept your reservation, the Housing Bureau will make reservations to fit your specifications elsewhere.

COLUMBUS

*** 106th Annual Session, May 1-4, 1960**



St. Francis Hospital



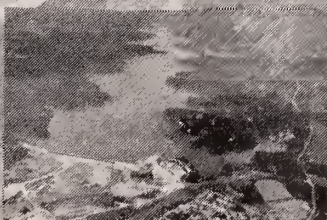
Martin Army Hospital



**The Infantry School
Fort Benning**



Bradley Museum



Oliver Dam



The Medical Center

OFFICIAL CALL

extended to all Officers and Members of the Medical Association of Georgia

The *106th Annual Session of the Medical Association of Georgia will be held in the Municipal Auditorium, Columbus, Georgia on May 1, 2, 3, and 4, 1960.

The MAG Official Registration Desk will be located inside the parking lot entrance of the Municipal Auditorium, adjacent to the main meeting hall and exhibit rooms. Registration for Association members and guests will be conducted Sunday, May 1 from 1:00 P.M. to 6:00 P.M. and Monday, May 2 and Tuesday, May 3 from 8:00 A.M. to 5:00 P.M.

The Association will convene a General Business Session for nomination to MAG Office, Sunday, May 1 at 2:00 P.M. in the Municipal Auditorium; a General Session Sunday evening at 8:30 P.M. for a Memorial Concert and an address by the Honorable S. Ernest Vandiver, Governor, State of Georgia in the Royal Theatre; a General Session (G.P. Day) Monday, May 2 at 9:00 A.M. in the Municipal

Auditorium; a General Business Session for the addresses of the MAG Presidents on Monday at 12:00 Noon in the Municipal Auditorium; and, a final General Business Session, Wednesday, May 4 at 11:30 A.M. in the Municipal Auditorium at which time Association awards are presented and new officers installed.

The Association House of Delegates will convene Sunday, May 1 at 5:00 P.M. in the Municipal Auditorium and will reconvene Wednesday, May 4 at 9:00 A.M. again in the Municipal Auditorium.

The Scientific Section Meetings will be convened in the Municipal Auditorium, the Naval Reserve Building adjacent to the Auditorium and Martin Army Hospital at Ft. Benning beginning Sunday afternoon, May 1 at 2:30 P.M.; Monday morning, May 2 at 9:00 A.M.; Monday afternoon, May 2 at 2:30 P.M.; Tuesday morning, May 3 at 9:00 A.M. and Tuesday afternoon, May 3 at 2:30 P.M. These Section Meetings are scheduled as follows:

Sunday, May 1

- 2:00 P.M. MAG General Business Session, *Municipal Auditorium*
- 2:30 P.M. Radiology, Pediatrics, Orthopedics, Surgery and Neurological Surgery Joint Section Meeting, *Municipal Auditorium*
- 2:30 P.M. General Practice and EENT Joint Section Meeting, *Navy Building Auditorium*
- 5:00 P.M. MAG House of Delegates Meeting, *Municipal Auditorium*
- 8:30 P.M. MAG General Session, *Royal Theater*

Monday, May 2

- 9:00 A.M. MAG General Session (G. P. Day), *Municipal Auditorium*
- 9:00 A.M. Georgia Radiological Society Business Meeting and Roentgen Interpretation Session, *Navy Building Auditorium*
- 12:00 NOON MAG General Business Session, *Municipal Auditorium*
- 1:00 P.M. MAG Indoctrination Luncheon for New Members, *Ambassador Restaurant*
- 2:30 P.M. Pediatrics and Radiology Joint Section Meeting, *Navy Building Auditorium*
- 2:30 P.M. Obstetrics and Gynecology, Medicine and General Practice Joint Section Meeting, *Municipal Auditorium*
- 2:30 P.M. Orthopedic and Pathology Joint Section Meeting, *Martin Army Hospital, Ft. Benning*

- 2:30 P.M. Urology Section Meeting, *Navy Building Classroom*
- 4:00 P.M. Neurological Surgery Organizational Meeting, *Navy Building Classroom*

Tuesday, May 3

- 9:00 A.M. Obstetrics and Gynecology, Medicine Diabetes and Dermatology Joint Section Meeting, *Municipal Auditorium*
- 9:00 A.M. Surgery, Orthopedics and Anesthesia Joint Section Meeting, *Navy Building Auditorium*
- 9:00 A.M. Pathology Section Meeting, *Navy Building Classroom*
- 2:00 P.M. General Practice, Orthopedics, Radiology, Neurological Surgery and Psychiatry Joint Section Meeting, *Municipal Auditorium*
- 2:15 P.M. Obstetrics and Gynecology Section Meeting, *Ambassador Restaurant*
- 2:30 P.M. Surgery and Anesthesiology Joint Section Meeting, *Martin Army Hospital, Ft. Benning*

Wednesday, May 4

- 9:00 A.M. MAG House of Delegates Meeting, *Municipal Auditorium*
- 11:30 A.M. MAG General Business Session, *Municipal Auditorium*

MAG OFFICERS

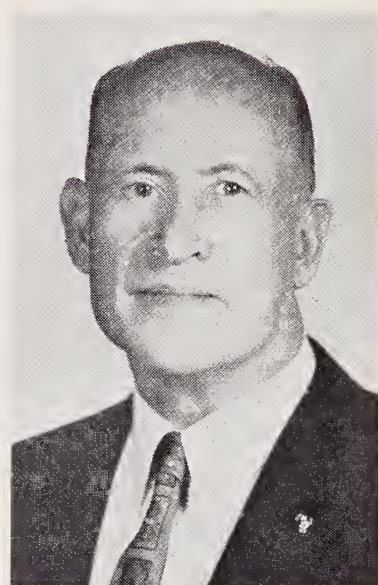
1959 - 1960



LUTHER H. WOLFF
President



CORBETT H. THIGPEN
First Vice-President



W. P. RHYNE
Second Vice-President



MILFORD B. HATCHER
President-Elect



CHRISTOPHER J. McLOUGHLIN
Secretary

OFFICERS AND COMMITTEES

President—Luther H. Wolff, Columbus (1960)

President-Elect—Milford B. Hatcher, Macon (1960)

Immediate Past President—Lee Howard, Sr., Savannah (1960)

First Vice-President—Corbett H. Thigpen, Augusta (1960)

Second Vice-President—W. P. Rhyne, Albany (1960)

Secretary—Chris J. McLoughlin, Atlanta (1960)

Speaker of the House—Thomas W. Goodwin, Augusta (1962)

Vice-Speaker of the House—Fred H. Simonton, Chickamauga (1962)

Honorary Advisory Board

<i>Past Presidents</i>	<i>Term</i>
J. W. Palmer, Ailey	1918-1919
C. K. Sharp, Arlington	1928-1929
William R. Dancy, Savannah	1929-1930
C. H. Richardson, Macon	1933-1934
Clarence L. Ayers, Toccoa	1934-1935
Grady N. Coker, Canton	1938-1939
Allen H. Bunce, Atlanta	1941-1942
James A. Redfearn, Albany	1942-1943
W. A. Selman, Atlanta	1943-1944
Cleveland Thompson, Waynesboro	1944-1945
Ralph H. Chaney, Augusta	1946-1947
Enoch Callaway, LaGrange	1949-1950
A. M. Phillips, Macon	1950-1951
W. F. Reavis, Waycross	1951-1952
C. F. Holton, Savannah	1952-1953
Wm. P. Harbin, Jr., Rome	1953-1954
H. Dawson Allen, Jr., Milledgeville	1955-1956
W. Bruce Schaefer, Toccoa	1957-1958
Lee Howard Sr., Savannah	1958-1959

Councilors

District

- 1—Charles T. Brown, Guyton (1961)
- 2—George R. Dillinger, Thomasville (1961)
- 3—W. G. Elliott, Cuthbert (1961)
- 4—Virgil Williams, Griffin (1961)
- 5—J. G. McDaniel, Atlanta (1962)
- 6—George H. Alexander, Forsyth (1962)
- 7—Ralph W. Fowler, Marietta (1962)
- 8—F. G. Eldridge, Valdosta (1962)
- 9—C. R. Andrews, Canton (1960)
- 10—Addison Simpson, Jr., Washington (1960)

Vice-Councilors

District

- 1—T. A. Peterson, Savannah (1961)
- 2—J. Z. McDaniel, Albany (1961)
- 3—Willis P. Jordan, Columbus (1961)
- 4—Jack H. Powell, Newnan (1961)
- 5—Charles S. Jones, Atlanta (1962)
- 6—W. H. M. Weaver, Macon (1962)
- 7—Ralph N. Johnson, Rome (1962)
- 8—James M. Hicks, Brunswick (1962)
- 9—Paul T. Scoggins, Commerce (1960)
- 10—David R. Thomas, Jr., Augusta (1960)

Delegates to the AMA

Delegate—J. W. Chambers, LaGrange (1961)
 Alternate—George R. Dillinger, Thomasville (1961)

Delegate—Eustace A. Allen, Atlanta (1960)
 Alternate—Thomas A. McGoldrick, Savannah (1960)

Delegate—Henry H. Tift, Macon (1960)
 Alternate—W. G. Elliott, Cuthbert (1960)

Committees of Council

Executive Committee

Luther Wolff, Columbus, *President, Chairman*
 Milford B. Hatcher, Macon, *President-Elect*
 Lee Howard, Sr., Savannah, *Immediate Past President*
 Chris J. McLoughlin, Atlanta, *Secretary*
 J. G. McDaniel, Atlanta, *Chairman of Council*
 Virgil Williams, Griffin, *Chairman of Finance*

Finance

Virgil Williams, Griffin, *Chairman*
 Charles R. Andrews, Canton
 George H. Alexander, Forsyth

Committee Reorganization

W. G. Elliott, Cuthbert, *Chairman*
 J. W. Chambers, LaGrange
 Thomas W. Goodwin, Augusta

Cultists

F. G. Eldridge, Valdosta, *Chairman*
 Robert L. Brown, Atlanta
 Raymond F. Spanjer, Cedartown
 Albert M. Deal, Statesboro

Councilor Apportionment and Redistricting

Thomas W. Goodwin, Augusta, *Chairman*
 Maurice F. Arnold, Hawkinsville
 George T. Nicholson, Cornelia

Standardization of Insurance Forms

Joseph B. Mercer, Brunswick, *Chairman*
 Charles T. Cowart, LaGrange
 W. Lynn Hicks, Macon

Institution-Physician Relations

F. G. Eldridge, Valdosta, *Chairman*
 Stewart D. Brown, Jr., Royston
 Darrell Ayer, Jr., Atlanta
 Lester Rumble, Jr., Atlanta
 George Schuessler, Columbus
 R. B. Martin, Cuthbert

Headquarters Building

C. J. McLoughlin, Atlanta, *Chairman*
 Lee Howard, Sr., Savannah
 J. G. McDaniel, Atlanta

Luther H. Wolff, Columbus
 Virgil Williams, Griffin
 Milford B. Hatcher, Macon

Medical School Course

C. J. McLoughlin, Atlanta, *Chairman*
 Rafe Banks, Jr., Gainesville
 T. A. Sappington, Thomaston

Clarksville Laboratory School

Charles Andrews, Canton, *Chairman*
 Hamil Murray, Gainesville
 Lee Howard, Jr., Savannah
 Paul T. Scoggins, Commerce
 Sam Talmadge, Athens

Annual Session

Henry H. Tift, Macon, *Chairman*
 George Alexander, Forsyth, *Co-Chairman*
 Peter Hydrick, College Park,
Commercial Exhibits
 Ted F. Leigh, Atlanta,
Scientific Exhibits and Meeting Room
 C. Raymond Arp, Atlanta, *Banquet*
 Simone Brocato, Columbus
 Mrs. A. Worth Hobby, Atlanta, *Ex-off*

Unauthorized Practice of Medicine by Ancillary Personnel

W. S. Dorough, Atlanta, *Chairman*
 Ralph W. Fowler, Marietta
 John T. Godwin, Atlanta

Distinguished Service Award

David Henry Poer, Atlanta, *Chairman*
 C. J. McLoughlin, Atlanta
 Virgil Williams, Griffin

Lectureship

George H. Alexander, Forsyth, *Chairman*
 Mark Dougherty, Jr., Atlanta
 J. W. Chambers, LaGrange

Health Care of the Aging

John S. Atwater, Atlanta, *Chairman*
 Harry Brill, Jr., Columbus
 Milford B. Hatcher, Macon
 T. A. Peterson, Savannah
 David R. Thomas, Jr., Augusta
 J. Frank Walker, Atlanta
 R. J. Van de Wetering, Atlanta
 H. J. Bickerstaff, Columbus
 Albert L. Morris, Fairburn
 John P. Heard, Decatur
 Robert L. Bennett, Warm Springs

SPECIAL COMMITTEES (Appointed Annually)

American Medical Education Foundation

George T. Nicholson, Cornelia, *Chairman*
T. A. Sappington, Thomaston
Harold Smith,
James Bell, Augusta
Alex Conger, Columbus
Monroe Templeton, Augusta
Jule Neal, Macon
J. Hubert Milford, Hartwell
Mrs. T. E. Dupree, Atlanta, *Ex-officio*

Blood Banks

Lester Forbes, Atlanta, *Chairman*
Lee Howard, Jr., Savannah
Walter L. Sheppard, Augusta
Hamil Murray, Gainesville
F. H. Thompson, Atlanta
Frank L. Beckel, Columbus
Joseph Hertell, Atlanta

Crippled Children

J. C. Hughston, Columbus, *Chairman*
F. James Funk, Jr., Atlanta
John L. Chandler, Jr., Augusta
H. M. Coe, Brunswick
Robert Mabon, Atlanta
J. W. Bennett, Augusta
W. G. Elliott, Cuthbert
Ruth Waring, Savannah
Atwood Freeman, Albany
Ernest Dunlap, Jr., Atlanta

STANDING COMMITTEES

Cancer

Hoke Wammock, Augusta, *Chairman*
Everett L. Bishop, Atlanta
J. E. Scarborough, Atlanta
David Henry Poer, Atlanta
R. C. Pendergrass, Americus
Wray J. Tomlinson, Columbus
John L. Barner, Athens
F. G. Eldridge, Valdosta
Lester Harbin, Rome
Thomas Harrold, Macon
M. Fernan Nunez, Dublin
Robert L. Brown, Atlanta
Neal F. Yeomans, Waycross
Julian B. Neel, Thomasville
Major F. Fowler, Atlanta
Wadley R. Glenn, Atlanta
John T. Mauldin, Atlanta
P. F. Brown, Jr., Gainesville
Enoch Callaway, LaGrange, *Ex-officio*

Crawford W. Long Memorial

Lester Rumble, Jr., Atlanta, *Chairman* (1961)
P. P. Volpitto, Augusta (1960)
Calvin S. Allen, Gainesville (1962)

Constitution and Bylaws

Thomas W. Goodwin, Augusta, *Chairman*
(1961)
Eustace A. Allen, Atlanta (1960)
Schley Gatewood, Americus

Geriatrics

Harry Brill, Columbus, *Chairman* (1961)
Edgar Woody, Jr., Atlanta (1960)
Milton F. Bryant, Atlanta (1962)

History and Vital Statistics

Carl C. Aven, Marietta, *Chairman* (1960)
Herbert Alden, Atlanta (1961)
Morgan Raiford, Atlanta (1962)
Edgar Woody, Jr., Atlanta, *Ex-officio*

Eyecare of the Newborn

J. Jack Stokes, Atlanta, *Chairman*
Thomas C. McPherson, Atlanta
Joseph L. Girardeau, Atlanta
C. A. N. Rankine, Atlanta
R. E. Fokes, Moultrie

Medical Civil Preparedness

Edgar M. Dunstan, Atlanta, *Chairman*
Lee Battle, Rome
Perry P. Volpitto, Augusta
J. Fletcher Hanson, Macon
T. J. Ferrell, Waycross
Joseph S. Skobba, Atlanta
Charles E. Dowman, Atlanta
George M. Hutto, Columbus
John L. Elliott, Savannah
Virgil B. Williams, Griffin
George R. Dillinger, Thomasville
Mrs. F. Kells Boland, Jr., Atlanta, *Ex-officio*

Ministerial Liaison

Needham B. Bateman, Atlanta, *Chairman*
Avery M. Dimmock, Atlanta
Marion A. Hubert, Athens
Edward Y. Walker, Milledgeville
F. G. Eldridge, Valdosta
H. H. Boyter, Columbus

Rehabilitation

Robert Bennett, Warm Springs, *Chairman*
James Funk, Atlanta

Jack Mahoney, Augusta
Vernon Powell, Atlanta
W. Upton Clary, Savannah
Hal S. Raper, Warm Springs
Mercer Blanchard, Columbus

Radiologic Safety

Robert M. Tankesley, Atlanta, *Chairman*
F. G. Eldridge, Valdosta
Enoch Callaway, LaGrange
Oliver T. Ghent, Gainesville
R. C. Pendergrass, Americus

School Child Health

Grady Black, Griffin, *Chairman*
Virginia McNamara, Atlanta
Robert N. Poole, Atlanta
M. D. Pittard, Toccoa
J. B. Morton, Moultrie
Wm. H. Bonner, Athens

VFW Liaison

Charles R. Andrews, Canton, *Chairman*
Chris J. McLoughlin, Atlanta

Weekly Health Column

H. C. Derrick, Jr., Lafayette, *Chairman*
C. J. Wyatt, Jr., Rome
J. Harry Lange, Atlanta
Lamar F. Glass, Atlanta
August S. Yochem, Jr., Atlanta
Jule C. Neal, Jr., Macon
E. P. Inglis, Marietta
T. J. Vansant, Marietta

R. H. McDonald, Newnan, *Ex-officio*
Mrs. Joe Daniel, Macon, *Ex-officio*

Hospital Relations

Milford B. Hatcher, Macon, *Chairman* (1961)
David Henry Poer, Atlanta, *Co-Chairman*
(1960)
Rafe Banks, Gainesville (1960)
J. Miller Byne, Waynesboro (1960)
H. C. Derrick, Jr., Lafayette (1960)
F. G. Eldridge, Valdosta (1960)
Herbert D. Tyler, Thomaston (1960)
Robert B. Martin, Cuthbert (1961)
James R. Paulk, Moultrie (1961)
Walter Brown, Savannah (1961)
W. L. Pomeroy, Waycross (1961)
Henry H. Tift, Macon (1961)
D. Lloyd Wood, Dalton (1962)
John Mauldin, Atlanta (1962)
Kirk Shepard, Thomasville (1962)
A. W. Simpson, Jr., Washington (1962)
Fred H. Simonton, Chickamauga (1962)
P. W. Warga, Athens (1962)
Mrs. Ted F. Leigh, Atlanta, *Ex-officio*
Mr. James Sitton, Atlanta, *Consultant*

Industrial Health

T. A. Peterson, Savannah, *Chairman* (1960)
Joe M. Bosworth, Atlanta (1960)
Alex Jones, Griffin (1961)
George Connor, Columbus (1962)

Insurance and Economics

David R. Thomas, Augusta, *Chairman* (1961)
Charles S. Jones, Atlanta, *Co-Chairman*
(1962)
John L. Elliott, Savannah (1960)
W. P. Rhyne, Albany
Thomas E. Floyd, Griffin (1960)
W. P. Nicholson, Atlanta (1961)
W. L. Pomeroy, Waycross (1962)
H. H. Hammett, LaGrange (1962)

Legislation

J. Frank Walker, Atlanta, *Chairman* (1960)
Eustace A. Allen, Atlanta, *Vice-Chairman*
(1962)
John Venable, Atlanta (1960)
John Bell, Dublin (1960)
Virgil B. Williams, Griffin (1961)
T. A. Peterson, Savannah (1961)
Albert M. Deal, Statesboro (1962)

Maternal and Infant Welfare

Eugene Griffin, Atlanta, *Chairman* (1962)
H. J. Bickerstaff, Columbus (1960)
James W. Bennett, Augusta (1960)
Peter Hydrick, College Park (1960)
Helen W. Bellhouse, Atlanta (1961)
Frank McKemie, Albany (1961)
A. G. LeRoy, Thomson (1962)
C. I. Bryans, Augusta (1962)

Medical Defense

Charles S. Jones, Atlanta, *Chairman* (1961)
W. Bruce Schaefer, Toccoa (1962)
Henry Finch, Atlanta (1963)
C. J. McLoughlin, Atlanta, *Ex-officio*
J. G. McDaniel, Atlanta, *Ex-officio*

Medical Education

C. F. Stone, Atlanta, *Chairman* (1960)
J. C. Metts, Savannah (1961)
J. Willis Hurst, Atlanta (1962)
Harry B. O'Rear, Augusta, *Ex-officio*
A. P. Richardson, Atlanta, *Ex-officio*

Mental Health

R. J. Van de Wetering, Atlanta, *Chairman*
(1961)
J. R. S. Mays, Macon (1960)
Paul T. Scoggins, Commerce (1960)
Richard E. Felder, Atlanta (1960)
Albert J. Kelley, Savannah (1961)

Standing Committees / continued

H. E. Valentine, Gainesville (1961)
William Rottersman, Atlanta (1962)
T. J. Vasant, Marietta (1962)
Guy V. Rice, Atlanta, *Consultant*
Trawick Stubbs, Atlanta, *Consultant*
Charles Smith, Columbus (1962)
Mrs. Rives Chalmers, Atlanta, *Ex-officio*

Professional Conduct

C. F. Holton, Savannah, *Chairman*
Wm. P. Harbin, Jr., Rome
H. Dawson Allen, Milledgeville
W. Bruce Schaefer, Toccoa
Lee Howard, Sr., Savannah

Public Health

H. J. Bickerstaff, Columbus, *Chairman* (1962)
Walter Brown, Savannah (1960)
J. B. Neighbors, Athens (1960)
Alex G. Little, Valdosta (1961)
Lee Battle, Jr., Rome (1961)
John Venable, Atlanta, *Ex-officio*

Public Service

John P. Heard, Decatur, *Chairman* (1961)
E. P. Inglis, Marietta (1960)
Frank McKemie, Albany (1960)
Peter L. Scardino, Savannah (1960)
E. C. McMillan, Macon (1961)
Dan B. Kahle, Atlanta (1961)
Charles W. Hock, Augusta (1961)
Simone Brocato, Columbus (1962)
Albert M. Boozer, Dalton (1962)
Alex Jones, Griffin (1962)
Mrs. T. L. Williams, Jr., Cordele, *Ex-officio*
Mrs. Louis H. Griffin, Claxton, *Ex-officio*

Rural Health

Albert L. Morris, Fairburn, *Chairman* (1961)
1—Katrine Hawkins, Sylvania (1960)
2—Carl Pittman, Jr., Tifton (1960)
3—Charles McArthur, Cordele (1962)
4—T. A. Sappington, Thomaston (1961)
5—Albert L. Morris, Fairburn (1960)

6—H. R. Cary, Milledgeville (1962)
7—H. C. Derrick, Lafayette (1961)
8—J. W. Yeomans, Jesup (1960)
9—Rafe Banks, Gainesville (1961)
10—Hugh B. Cason, Warrenton (1962)

Scientific Exhibit Awards

Ted F. Leigh, Atlanta, *Chairman* (1960)
Henry H. Boyter, Columbus (1961)
Hoke Wammock, Augusta (1962)

Veterans' Affairs

Lee Howard, Jr., Savannah, *Chairman* (1961)
Hartwell Joiner, Gainesville (1961)
F. P. Holder, Eastman (1962)

Woman's Auxiliary

Virgil B. Williams, Griffin, *Chairman* (1960)
W. G. Elliott, Cuthbert (1960)
Remer Y. Clark, Marietta (1962)

STATE BOARDS — RELATED COMMITTEES

State Board of Health

Fred H. Simonton, Chickamauga, *Chairman*
J. G. Williams, D.D.S., Atlanta, *Co-Chairman*
J. M. Byne, Jr., Waynesboro
A. G. Funderburk, Moultrie
M. F. Arnold, Hawkinsville
Virgil Williams, Griffin
Harold McDonald, Atlanta
A. M. Phillips, Macon
A. G. Little, Jr., Valdosta
Ben K. Looper, Canton
D. N. Thompson, Elberton
J. M. Hawley, D.D.S., Columbus
J. B. Butts, Ph.G., Milledgeville
W. W. Webb, Ph.G., Leslie

Georgia Joint Council to Improve the Health Care of the Aging

John S. Atwater, Atlanta, *Chairman*
Ernest Mingledorf, Atlanta
Mr. Millard Wear, Marietta
Mr. Fred Gunter, Marietta
Mr. Glenn Hogan, Atlanta
Mrs. Viola Caudill, Atlanta
Mrs. Mary G. Smith, Atlanta
Miss Daisy Eubanks, Atlanta
Mr. John H. Burkett, Atlanta
Mr. Milton D. Krueger, Atlanta

Hospital Advisory Committee (State Department of Public Health)

W. L. Pomeroy, Waycross
Rafe Banks, Jr., Gainesville
Milford B. Hatcher, Macon
David Henry Poer, Atlanta
P. W. Wurga, Athens
T. F. Sellers, Atlanta
Mr. Frank W. Allcorn, Warm Springs
Thomas Conner, D.D.S., Atlanta
Mr. Terry Hiers, Jr., Americus
Mr. Oscar S. Hilliard, Ft. Oglethorpe
Miss Dana Hudson, Atlanta
Mr. A. P. Jarrell, Atlanta
Mr. George E. Linney, Griffin
Mr. J. J. McLanahan, Elberton
Mr. Louis Newmark, Atlanta

Hospital Care Council

Mr. Oscar S. Hilliard, Ft. Oglethorpe, *Chairman*
Mr. Frank W. Allcorn, Jr., Warm Springs, *Co-Chairman*

Mr. John W. Collins, Atlanta, *Secretary*
Mr. George L. Mathews, Americus
A. B. Conger, Columbus
W. Bruce Schaefer, Toccoa
Mr. Frank L. Baker, Jr., Rome
Mr. James E. Evitt, Ringgold
Mr. O. B. Hardy, Albany
Mr. Jeff Gilreath, Cartersville
T. F. Sellers, Atlanta, *Ex-officio*
Judge Alan Kemper, Atlanta, *Ex-officio*

Georgia Hospital-Medical Mediation Council

Mr. Millard L. Wear, Marietta (G.H.A.)
Mr. Whitelaw H. Hunt, Augusta (A.C.H.A.)
Mr. Frank W. Allcorn, Jr., Warm Springs (Gov. Boards)
Mr. David Hamilton, Atlanta (Gov. Boards)
Milford B. Hatcher, Macon (MAG)
Mr. Arthur W. Smith, Macon
Mr. James Sittion
Fred H. Simonton, Chickamauga (GAGP)
Mark S. Dougherty, Atlanta (MAG)
George M. Hutto, Columbus (Radio.-Anes.-Path.)
John Mauldin, Atlanta (ACS)

State Board of Medical Examiners

L. W. Willis, Bainbridge, *President*
Paul Scoggins, Commerce
Carl Savage, Montezuma
Alex Russell, Winder
J. W. Palmer, Ailey
Q. A. Mulkey, Millen
R. H. McDonald, Newnan
Fred J. Coleman, Dublin
Grady N. Coker, Canton

State Medical Education Board

Raymond Evans, Sr., Clayton, *Chairman*,
March 31, 1961
Mr. L. R. Seibert, Atlanta, *Secretary-Treasurer*
Lee Howard, Sr., Savannah, May, 1960
Herman Dismuke, Ocilla, March 31, 1961
J. C. Tanner, Jr., Atlanta, March 31, 1961

Interprofessional Council of Georgia

W. A. Carr, D.D.S., Augusta, *Chairman*
George Mudter, Ph.G., Manchester, *Vice-Chairman*
Irwin T. Hyatt, D.D.S., Atlanta
Robert C. Powell, D.D.S., Rome

C. J. McLoughlin, Atlanta
John G. Wells, Newnan
John K. Davidson, Columbus
J. V. Riley, Ph.G., Atlanta
Tyre Watson, Jr., Ph.G., Decatur

Physician-Lawyer Liaison

W. Bruce Schaefer, Toccoa
W. L. Pomeroy, Waycross
Charles S. Jones, Atlanta
Mr. S. E. Kelly, Columbus
Mr. Maylor B. Clinkscales, Commerce
Mr. John Dunaway, Atlanta

Talmadge Hospital Liaison

MAG—C. H. Richardson, Sr., Macon, *Chairman*
RCMS—Gordon Kelly, Augusta
A. J. Waters, Augusta
MCG—Harry B. O'Rear, Augusta
Edgar Pund, Augusta
1st—J. Miller Byne, Waynesboro
2nd—W. P. Rhyne, Albany
3rd—Henry Boyter, Columbus
4th—J. R. Turner, LaGrange
5th—Lamar Peacock, Atlanta
6th—Milford B. Hatcher, Macon
7th—Ralph Fowler, Marietta
8th—R. A. Pumpelly, Jesup
9th—A. A. Rogers, Jr., Commerce
10th—Stewart D. Brown, Royston

Governor's Commission on Aging

John Tyler Mauldin, *Chairman*
Mrs. Virginia Smyth, *Vice-Chairman*
C. S. Hubbard
Honorable Phil Cawthon
Honorable Bruce Hall
Honorable L. C. Butcher
Honorable R. L. Vasant
John S. Atwater
Honorable B. Fred Statham
Hugh B. Masters
Miss Mary Athearn
Mrs. Elizabeth S. Lipscomb
Honorable Clifford M. Clarke, Jr.
Ernest Mingledorf
Honorable Millard L. Wear
Honorable John Davis
Honorable Monroe Kimbrell
Rev. Harvey R. Mitchell
Honorable John L. Caldwell
Honorable Peyton S. Hawes
Honorable Clement J. Ford

ANNUAL SESSION COMMITTEES

Annual Session General Chairman

Simone Brocato, *Chairman*

Auxiliary Liaison

Waverly B. Dashiell, *Chairman*
S. A. Roddenbery

Credentials and Registration

George S. Whatley, *Chairman*
Richard A. Dodelin

Nance

James A. Elkins, *Chairman*
Willis P. Jordan

Polk

Polk S. Land, *Chairman*

Edgar B. Horn
Roy M. Waller, Jr.

Hospitality and Entertainment

Henry H. Boyter, *Chairman*
Clarence Butler
Jack C. Hughston
H. Quigg Fletcher, Jr.
Brent Fox
William G. Love, Jr.
Charles R. Smith
P. C. Graffagnino
R. A. Chipman
Robert M. Flowers
Harold G. Jarrell
James W. Rhea

Housing

Harry H. Brill, Jr., *Chairman*
A. B. Conger
W. G. Thwaite
Ralph E. Tiller

Publicity

Dave Berman, *Chairman*
John H. Deaton
Jack Hirsch

Transportation

Bruce C. Newsom, *Chairman*
W. D. Varner
James Ward
Lionel M. Yoe

Specialty Society Program Chairmen

Georgia Society of Anesthesiologists

George E. Donaghy

Georgia Chapter, American College of Chest Physicians and Georgia Trudeau Society

Robert H. Vaughan

Georgia Society of Dermatologists

Dave Berman

Georgia Diabetes Association

John K. Davidson

Georgia Society of Ophthalmology and

Otolaryngology

Floyd C. Jarrell, Jr.

Georgia Academy of General Practice

C. Denton Johnson

Georgia Chapter, American College of Physicians and Georgia Heart Association

Simone Brocato

Neurological Surgery and Neurology

Louis Hazouri

Georgia State Obstetrical and Gynecological Society

P. C. Graffagnino

Georgia Orthopedic Society

Jack C. Hughston

Georgia Association of Pathologists

Wray J. Tomlinson

Georgia Pediatric Society

Mercer Blanchard, Sr.

Georgia Psychiatric Association

Luther J. Smith

Georgia Radiology Society

George Hutto

Georgia Chapter, American College of Surgeons

S. A. Roddenbery

Georgia Urological Society

Franklin D. Edwards

Martin Army Hospital, Ft. Benning

Col. Robert Hoagland

Information

Registration

The Medical Association of Georgia official registration desk will be located just inside the parking lot entrance of the Municipal Auditorium adjacent to the Meeting Hall and exhibit room entrance. It will be open for registration of Association members and guests at 1:00 P.M., Sunday, May 1, 1960 and 8:00 A.M. Monday and Tuesday, May 2 and 3. Members and guests should register there *immediately upon arrival* to obtain badges and programs. No one will be admitted to the exhibit room and meeting hall without official badges.

Message Center and General Information

A message center will be maintained at the MAG Official Registration Desk. Pages from the Woman's Auxiliary to the Medical Association of Georgia

will staff this center during the entire session. All notices of an official nature will be posted on the official bulletin board at the message center.

Headquarters Office and Press Room

The Association Headquarters Office staff will maintain a MAG Headquarters Office Room in the Municipal Auditorium near the MAG Official Registration Desk. A Press Room for the Association Annual Session and the Auxiliary Convention publicity will also be maintained in the Municipal Auditorium.

House of Delegates

The MAG House of Delegates will meet Sunday afternoon, May 1 at 5:00 P.M. in the Municipal Auditorium and will reconvene Wednesday, May 4 at 9:00 A.M. again in the Municipal Auditorium.

Information

All MAG delegates are requested to attend both of these sessions of the House of Delegates *15 minutes prior to the time they are convened*, so that the delegates may be registered on the official roll. Delegates registration will be held just outside the main meeting hall at the end of the commercial exhibits room in the Municipal Auditorium.

Memorial Service

The Medical Association of Georgia will hold its annual Memorial Service at the opening session of the House of Delegates at 5:00 P.M. Sunday, May 1 in the Municipal Auditorium. All members are cordially invited to attend. This service is held in memory of the members who have died during the past year.

T. F. Abercrombie, Decatur, June 14, 1959
J. George Bachmann, Atlanta, November 28, 1959
C. C. Benton, Macon, August 22, 1959
James N. Brawner, Atlanta, March 8, 1959
J. A. Bussell, Rochelle, July 15, 1959
Walter H. Cargill, Atlanta, October 26, 1959
J. H. Edge, Atlanta, January 6, 1959
H. G. Estes, Atlanta, June 6, 1959
W. M. Flanagan, Waycross, November 20, 1959
Maude E. Foster, Atlanta, July 30, 1959
C. Glenville Giddings, Atlanta, November 29, 1959
W. Mayes Gober, Dial, September 4, 1959
G. W. Hammond, Newnan, January 11, 1960
Sage Harper, Douglas, May 26, 1959
W. B. Harrison, Athens, July 8, 1959
H. P. Hitchcock, Augusta, August 7, 1959
K. S. Hunt, Griffin, July 28, 1959
W. J. Hutchins, Buford, November 19, 1959
Bruce Jackson, Newnan, July 28, 1959
J. M. Kenyon, Richland, September 17, 1959
George P. Kinnard, Newnan, March 2, 1959
O. W. Kitchens, Byromville, June 1, 1959
L. Fielding Lanier, Sylvania, May 10, 1959
J. W. Mayher, Columbus, July 11, 1959
F. X. Mulherin, Augusta, March 14, 1959
J. C. Patterson, Cuthbert, November 8, 1959
J. L. Porter, Rutledge, September 23, 1959
W. Earl Quillian, Atlanta, November 5, 1959
F. S. Rogers, Coleman, June 17, 1959
T. E. Rogers, Macon, January 19, 1960
H. F. Shields, Chickamauga, May 8, 1959
J. W. Simmons, Brunswick, May 9, 1959
Claude E. Tessier, Augusta, September 12, 1959
Bert Tillery, Columbus, September 21, 1959
W. D. Willcox, Fitzgerald, October 1, 1959
W. E. Wofford, Cartersville, December 13, 1959

Specialty Society Luncheons and Dinners

Certain specialty societies plan to have luncheons on Sunday afternoon, Monday afternoon and Tuesday afternoon and dinners on Sunday night during the Association's Annual Session. These events are

listed in the official program even though they are not a part of the official program, so please check there for specific time and place.

Woman's Auxiliary

The Woman's Auxiliary to the Medical Association of Georgia will have its Registration Desk in the main lobby of the Ralston Hotel. Auxiliary meetings will be held in the Ralston Hotel. The Auxiliary Desk in the lobby of the Ralston Hotel will be opened Sunday May 1 from 11:00 A.M. to 5:00 P.M.; Monday, May 2 from 8:30 A.M. to 3:30 P.M. and Tuesday, May 3 from 9:00 A.M. to 12:30 P.M. The complete program giving the times and locations of the meeting of the 35th Annual Meeting of the Woman's Auxiliary to the Medical Association of Georgia will be found beginning on Page 158.

Social Events

Information about social events planned in conjunction with the MAG Annual Session and the necessary tickets will be available at the MAG Official Registration Desk. Your cooperation in purchasing your tickets for these social events at the time you register is *requested*. Accommodations for social events are limited and the sponsoring groups cannot be held responsible unless everyone cooperates in this regard. The traditional Alumni social hours and dinners for the Medical College of Georgia and the Emory University School of Medicine will be held Monday evening, May 2.

Scientific Exhibits

Scientific Exhibits will be displayed adjacent to the commercial exhibits in the Municipal Auditorium. These exhibits are of great interest to the membership and are prepared by physicians who will be on hand to discuss their exhibit with you. All members are urged to visit each scientific exhibit in the interest of professional education. A list of the scientific exhibits is as follows:

"Ankle Sprains and Subluxations": George S. Whatley, M.D., Columbus, Georgia.

"Bone Tumors": Richard A. Dodelin, M.D., Columbus, Georgia.

"Intra-arterial Large Particle Isotopes and Isolation-Perfusion with Chemicals for Advanced Cancer": Edgar D. Grady, M.D.; Walter Sale, M.D.; William E. Schatten, M.D., and Luther Rollins, M.D., Atlanta, Georgia.

"Cardiac Resuscitation": William A. Hopkins,

Information

M.D.; James B. Minor, M.D.; M. Bedford Davis, M.D., and William C. Wansker, M.D., Atlanta, Georgia.

"The Role of the Private Psychiatric Hospital in Mental Health": James N. Brawner, Jr., M.D. and Albert F. Brawner, M.D., Atlanta, Georgia.

"Guide to Good Eating for Better Family Health": Dairy Council of Chattahoochee Valley, Savannah, and Macon-Warner Robins.

"Surgery of the Tympanic Membrane and Middle Ear": Claude L. Pennington, M.D., Macon, Georgia.

"Muscogee County Chapter, American Association of Medical Assistants": Officers and members of the Muscogee County Chapter, American Association of Medical Assistants.

"Cystic Fibrosis": Needham B. Bateman, M.D.; John Rhodes Haverty, M.D., and Richard King, M.D., Atlanta, Georgia.

"Femoral Shortening": Piedmont Orthopedic Society and Jack C. Hughston, M.D., Local Exhibitor, Columbus, Georgia.

"Automotive Crash Injury Research": ACIR Project, Cornell University, Ithaca, New York.

Commercial Exhibits

Approximately 51 commercial exhibits will be displayed in exhibit booths adjacent to the main meeting hall in the Municipal Auditorium. These exhibits will give up-to-date information on the latest products and services available to the medical profession.

It is *extremely* important that you visit each of these exhibits and register with the exhibitor. Your cooperation is *requested* since these displays are designed and shown specifically for your benefit. The exhibitor plays an extremely important roll in making this Annual Session possible and the Association Commercial Exhibit Committee strongly urges your participation in this area of Association activity. A list of these exhibits is given as follows:

Booth Number	Name of Company
1	Knoll Pharmaceutical Company, Orange, New Jersey
2	Eli Lilly and Company, Indianapolis, Indiana
3	Wm. S. Merrell Company, Cincinnati, Ohio
4	Sandoz Pharmaceuticals, Hanover, New Jersey
5	Charles G. Haskell and Company, Richmond, Virginia
6	J. B. Roerig and Company, New York, N. Y.
7	William H. Rorer, Inc., Philadelphia, Pennsylvania
8	Ortho Pharmaceutical Corporation, Raritan, New Jersey
9	Davies, Rose and Company, Ltd., Boston, Massachusetts
10	Lederle Laboratories, Pearl River, New York
11	Ross Laboratories, Columbus, Ohio
12	The Upjohn Company, Kalamazoo, Michigan
13	Merck, Sharp and Dohme, Philadelphia, Pennsylvania
14	A. S. Aloe and Company, Chamblee, Georgia
15	Julius Schmid, Inc., New York, N. Y.
16	Wm. P. Poythress and Company, Inc., Richmond, Virginia
17	Doho Chemical Corporation, New York, N. Y.
18	Pfizer Laboratories, Brooklyn, New York
19	Carnation Company, Los Angeles, California
20	Estes Surgical Supply Company, Atlanta, Georgia
21	Purdue Frederick Company, New York, N. Y.
22	Geigy Pharmaceuticals, Yonkers, New York
23	The Coca-Cola Company, Atlanta, Georgia
24	The Bordon Company, New York, N. Y.
25	A. H. Robins Company, Richmond, Virginia
26	Winthrop Laboratories, New York, N. Y.
27	Schieffelin and Company, New York, N. Y.
28	U. S. Vitamin and Pharmaceutical Corp., New York, N. Y.
29	The Stuart Company, Pasadena, California
30	Smith, Kline and French Laboratories, Philadelphia, Pennsylvania
31	Durr Surgical Supply Company, Montgomery, Alabama
32	Warren-Teed Products Company, Columbus, Ohio
33	Medco Products Company, Inc., Tulsa, Oklahoma
34	Desitin Chemical Company, Providence, Rhode Island

Information

- 35 Vanpelt and Brown, Inc., Richmond, Virginia
- 36 Carrtone Laboratories, Inc., Metairie, Louisiana
- 37 Mead Johnson and Company, Evansville, Indiana
- 38 Schering Corporation, Bloomfield, New Jersey
- 39 S. E. Massengill Company, Bristol, Tennessee
- 40 Westinghouse Electric Corporation, Atlanta, Georgia
- 41 The Lanier Company (Gray Audograph), Atlanta, Georgia
- 42 Parke Davis and Company, Atlanta, Georgia
- 43 Ciba Pharmaceutical Products, Inc., Summit, New Jersey
- 44 Smith, Miller and Patch, Inc., New York, N. Y.
- 45 Westwood Pharmaceuticals, Buffalo, New York
- 46 Warner-Chilcott Laboratories, Morris Plains, New Jersey
- 47 G. D. Searle and Company, Chicago, Illinois
- 48 Abbott Laboratories, North Chicago, Illinois
- 49 Donley-Evans and Company, St. Louis, Missouri
- 50 Surgical Selling Company, Atlanta, Georgia
- 51 Eaton Laboratories, Norwich, New York

Fifty Year Members

The following list contains the names of all the members of the Medical Association of Georgia who as of this year, 1960, have practiced medicine for fifty years. It does not record the names of physicians who have already received gold membership cards. This is the class of 1959 only, as follows:

Carl C. Aven	Atlanta
Victor H. Bennett	Gay
J. E. Davis	Atlanta
H. L. Earl	Sparta
Clifford C. Elliott	Sargent
Claude W. Harvey	Hoganville
W. F. Massey	Chester
Robert L. Rhodes	Augusta
Jos. R. Robertson	Augusta
Thomas E. Rogers	Macon (Deceased)
Dan Y. Sage	Atlanta
Ralph C. Williams	Atlanta

Transportation

Because the locations of hotel accommodations and meeting rooms are somewhat distant, it is planned to have a shuttle bus service for members of the Association. The membership is urged to use their own automobiles when possible, but there will be available at certain specified times chartered buses to transport physicians to and from the scheduled events listed in the program. Specific information on the shuttle bus schedules will be available at the MAG Official Registration Desk.

VOTING RULES

Bylaws, Chapter V, Election of Officers

SECTION 3, METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SECTION 4. TIME. Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the annual session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

president's letter

MAY 1st TO THE 4th, 1960!

THESE ARE THE DATES of the State Meeting of the Medical Association of Georgia at Columbus!

These are the dates for which Muscogee County, Columbus, the members of the Muscogee County Medical Society wish to extend to you a most cordial and warm invitation to visit us. This Annual Meeting of the Medical Association of Georgia represents a truly historical event for the Muscogee County Medical Society. It is the first Annual Meeting to be held in Columbus in over 50 years. We, the practicing physicians in Columbus, think Columbus is a wonderful town; we are proud of it. We want you to know it and to know us. We can reasonably promise a most profitable and enjoyable visit with us.

Every detail for your convenience, comfort, and enjoyment has been carefully worked out by the Committee on Local Arrangements, which, in fact, means the entire membership of the Muscogee County Medical Society.

We can assure you of a scientific program that is the peer of any state or national program. Many of the most distinguished personalities in American medicine will be present to give you of their wisdom and knowledge. Some of the sessions include visits to the Martin Army General Hospital at Fort Benning. The personnel of this institution have entered wholeheartedly and enthusiastically into making this meeting a success.

The Governor of our great State will address the members of the Medical Association of Georgia, their wives, and guests on Sunday evening. The Governor's address will follow a Symphony Concert given as a Memorial to the late Dr. A. C. Hobbs by the Columbus Symphony Orchestra. We envision a large and responsive audience for these two unusual features of the program. Various forms of entertainment are planned for your participation, including golf tournaments, a bridge tournament, and the usual Alumni Dinners. The President's Banquet on Tuesday evening promises to be a most delightful affair.

Again, may I urge you to mark these days on your calendars as the days you will be in Columbus? We want you to come and we are convinced that you will enjoy every day of the Meeting!



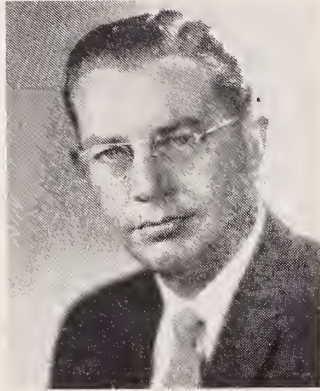
Luther H. Wolff

LUTHER H. WOLFF, M.D.,

President, Medical Association of Georgia

GUEST SPEAKERS

S. Ernest
Vandiver, Governor
State of Georgia



HONORABLE S. ERNEST VANDIVER, Governor of the State of Georgia, will give an address at 9:00 P.M., Sunday, May 1, to the MAG General Session. All MAG and Auxiliary members and guests are invited. Governor Vandiver's address is entitled "Your State Government and the Medical Profession."

During his career, Governor Vandiver has served his people as Lieutenant Governor, as Adjutant General at the head of the State Military Department, and as head of the State's Civil Defense pro-

gram. He also served as mayor of his home town, Lavonia, being the youngest man ever to fill that position.

Governor Vandiver's entry into the Georgia political field was during the last race for governor which was run successfully by the late Governor Eugene Talmadge.

Upon the death of Governor Eugene Talmadge the young leader from Lavonia gave his support to United States Senator Herman Talmadge. Appointment of Vandiver as Adjutant General of Georgia was one of the first official acts of Herman Talmadge when he assumed the duties of the governor's office in 1949.

After serving as Lieutenant Governor, Mr. Vandiver became the almost unanimous choice of the people of Georgia for the position of chief executive.

Mr. Vandiver attended the Darlington School at Rome and later went to the University of Georgia where he received his law degree. At the University, he demonstrated rare qualities of leadership by serving as president of five varied societies, fraternities, and councils and was a member of nine additional ones.

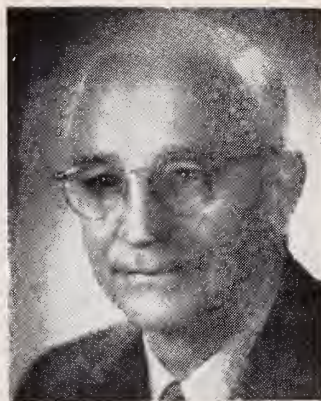
Lenox D.
Baker, M.D.
Durham, N. C.



LENOX D. BAKER, M.D., Durham, North Carolina, is Professor of Orthopedics at Duke University School of Medicine and Medical Director of North Carolina Cerebral Palsy Hospital in Durham.

On Sunday, May 1, at 3:00 P.M., Dr. Baker will deliver a paper entitled "Indications for Early Surgery in Cerebral Palsy." A brief precis of Dr. Baker's paper follows:

This paper deals with the early recognition of the cerebral palsy quadrad of deformities pes planus, equinus, knee flexion, and hip flexion adduction. The importance of early recognition and correction to prevent permanent changes will be discussed. An attempt will be made to show the indications for and results that can be obtained from certain well known orthopedic surgical procedures frequently used in poliomyelitis but seldom attempted in the treatment of the patient with cerebral palsy. The lack of the application of these procedures to patients with cerebral palsy due to fallacies that have grown up around the use of surgery in the treatment of this disease will be reviewed and an attempt will be made to point out why the results from surgery in cerebral palsy have not been and will not be as satisfactory nor as predictable as in other diseases, but, nevertheless, are needed early before fixed and irreparable deformities develop.



Owen H.
Wangensteen, M.D.
Minneapolis, Minn.

OWEN H. WANGENSTEEN, M.D., Minneapolis, Minnesota, received his M.D. degree from the University of Minnesota. He has been Chairman of the Department of Surgery at the University of Minnesota since 1930.

Dr. Wangensteen will give an address on Tuesday, May 3, at 11:20 A.M. entitled "Local Gastric Cooling of Massive Gastric Hemorrhage." A brief precis of the paper follows:

Local gastric hynothermia has served to indicate the key role of pepsin in ulcer genesis. Esophageal perfusion studies have shown that 0.1 HCl fails to damage the esophageal mucosa of an intact cat over a two-hour perfusion period. Temperature variations within the physiological range do not affect the issue. Similar perfusions of gastric juice, obtained by overnight aspirations from patients with active duodenal ulcers, in the same pH range, lead to perforation of the cat's esophagus in the same period of time in about 75 per cent of instances.

Inhibition of peptic activity attends employment of hypothermia in frog, rat, rabbit, dog, and man. Only in fish has peptic activity at low temperatures been noted (2-5 degrees C.).

Experience with the use of local gastric hypothermia in massive gastric hemorrhage for a variety of clinical conditions will be reviewed briefly; advantages and limitations of the method will be pointed out.

Dr. Wangensteen will also present another paper at 4:00 P.M. on Tuesday, May 3, entitled "Extended Operation for Alimentary Tract Malignancy." The following is a summary of Dr. Wangensteen's paper:

The common denominator of cancer of the esophagus and stomach is increasing years. The mean age of patients admitted for surgery for cancer of the stomach is 65 years (males 66.2; females 61.2). The silent interval of gastric cancer is in the area of two years. It is during this long incubation period, when the patient is still asymptomatic, that detection of the cancer would afford the best chances for cure.

Cancer of the stomach is sufficiently frequent in both men and women, to justify unrelenting efforts by the medical profession to continue a search for methods of recognizing the presence of the cancer in asymptomatic patients past 50 years of age. We still lack a satisfactory screening test for gastric cancer. The best available test is ascertainment of histamine achlorhydria by gastric aspiration. Patients who are achlorhydric or hypochlorhydric on histamine stimulation (under 30 degrees free HCl) should have yearly X-ray examinations of the stomach. Gastric washings in such patients, too, may prove of value in cancer detection. Gastroscopic examination is a valuable diagnostic agent occasionally. The most valuable aid in the detection of gastric cancer has been X-ray studies. It is doubtful, however, whether asymptomatic mucosal gastric cancers can be recognized by this means. The experience of this clinic with use of radioactive phosphorus (P32) will be described.

In patients admitted to the University of Minnesota Medical Center operated upon for gastric cancer, the five-year survival rate in patients having no regional lymph-node involvement is in the area of 60 per cent. Whereas, aggressive surgery for advanced gastric cancer will salvage a few lives, the important hope for patients having gastric cancer is detection of the cancer in the asymptomatic stage.

Total or near-total colectomy for cancer of the colon will be described, together with our experiences with the second-look procedures.



Francis
Murphey, M.D.
Memphis, Tenn.

FRANCIS MURPHEY, M.D., Memphis, Tennessee, will deliver a paper entitled "The Diagnosis and Surgical Treatment of Extracranial Occulsive Vascular Disease, A Common Cause of Strokes" at 3:00

P.M., Tuesday, May 3. The following is a short precis of that paper:

The mechanisms by which extracranial occlusive disease may cause symptoms and the methods whereby correct diagnosis may be made will be discussed in detail. Even more emphasis will be placed on the selection of patients to be operated upon as well as those to be treated medically. The surgical technique will be presented followed by the results, complications, and fatalities following surgery.

Dr. Murphey received his B.A. degree from Vanderbilt University and his M.D. degree from Harvard Medical School. He is Professor of Neurosurgery at the University of Tennessee College of Medicine, Chief of Neurosurgery at the Baptist Memorial Hospital and City of Memphis Hospital, and is a member of the American Academy of Neurological Surgeons.

John J.
Shea, M.D.
Memphis, Tenn.



JOHN J. SHEA, M.D., Memphis, Tennessee, received his M.D. degree from Harvard Medical School and is now with the Baptist Memorial Hospital in Memphis.

Dr. Shea will present a paper at 3:30 P.M., Sunday, May 1, entitled "Four Years Experience with Fenestration of the Oval Window." A short summary of his paper follows:

The first fenestration of the oval window for otosclerosis was done four years ago. The stapes was removed, the fenestra in the oval window covered with a slice of subcutaneous tissue, and the sound conducting mechanism rebuilt with a Teflon replica of the stapes. The patient's hearing was improved.

A vein graft was quickly substituted for the slice of subcutaneous tissue, and a polyethylene strut for the teflon replica of the stapes.

I have done more than 1,000 fenestration of the oval window operations myself, with increasing safety and success so that now more than 90 per cent of the patients are returned to useful hearing. The operation has spread throughout the world, and the concept of fenestration of the oval window and rebuilding the sound conducting mechanism has reached almost universal acceptance.

Paul
Winchell, M.D.,
Minneapolis, Minn.



PAUL WINCHELL, M. D., Minneapolis, Minnesota, is Assistant Professor of Medicine and Assistant Professor in the Graduate School of the University of Minnesota.

Dr. Winchell will present a paper entitled "Physi-

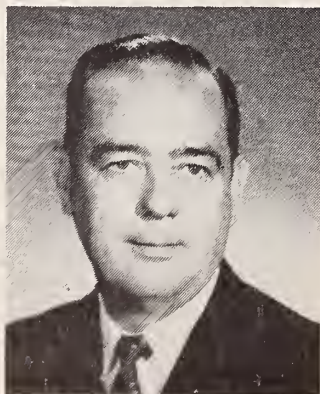
ological Changes in the Cardiovascular System During Pregnancy" at 2:50 P.M., Monday, May 2. A short precis follows:

This paper will present a brief summary of the changes that occur in primarily the total extracellular fluid volume as well as specifically the blood volume during pregnancy as well as other less important changes in heart rate, blood pressure, etc. The alterations in cardiac work that ensue will then be presented and finally correlations between the physiological changes and the changing clinical picture during pregnancy will be drawn.

He will also present another paper at 9:30 A.M., Tuesday, May 3, entitled "Medical Management of Heart Disease During Pregnancy." A summary follows:

This paper will deal in general terms with the rationale and techniques for managing the pregnant woman with heart disease. In addition, the points will be emphasized that therapeutic abortion, for practical purposes, is never indicated and that maternal mortality from heart disease is virtually non-existent, under proper circumstances.

Louis P.
Britt, M.D.
Memphis, Tenn.



LOUIS P. BRITT, M.D., Memphis, Tennessee, is

an Instructor in Orthopedic Surgery at the University of Tennessee, Medical Director of Les Pas-sees Center, and is on the Consulting Staff of Methodist Hospital, Baptist Memorial Hospital, and LeBonheur Children's Hospital in Memphis.

Dr. Britt will present a paper at 3:30 P.M., Tuesday, May 3, entitled "Physical Rehabilitation of the Stroke Patient." A brief summary follows:

Discussion of the physical rehabilitation program for the stroke individual will include prevention of deformities, muscle re-education, bed activities, wheel chair activities, ambulation, self-care, bracing, communication, and social and economic adjustment.



**Edward B. D.
Neuhauser, M.D.**
Boston, Mass.

EDWARD B. D. NEUHAUSER, M.D., Boston, Massachusetts, is Radiologist in Chief at the Children's Hospital of Boston; Consultant in Radiology to the Boston Lying-In Hospital; Consultant in Radiology to the Peter Bent Brigham Hospital; Consultant in Roentgenology to the U. S. Naval Hospital, Chelsea; Associate Clinical Professor in Radiology, Children's Hospital, Harvard Medical School; Consultant in Radiology, House of Good Samaritan, and Consultant in Radiology, International Grenfell Association Hospital, St. Anthony, Newfoundland.

Dr. Neuhauser will present a paper entitled "Lesions of the Neuroenteric Canal" at 2:30 P.M., Sunday, May 1. A short precis of his paper follows:

The neuroenteric canal is a normal, but evanescent structure occurring in early embryonic life; is a passage that

extends from the primitive gut posteriorly through the mid-line to the yolk sac. It is normally obliterated. Remnants of this canal or perhaps even remnants of accessory neuroenteric canals may persist, giving rise to a variety of lesions difficult to explain embryologically unless a complete understanding of the many possibilities is attained.

The clinical and roentgen findings in a variety of these lesions will be presented, varying from simple dorsocutaneous fistulae, intraspinal cysts, anterior neuroenteric cysts, and extensive duplication of the bowel, as well as diastematomyelia. Although many of the lesions are rare, the total summation of the possibilities makes defects with this presumed origin not at all infrequent.

On Monday, May 2, at 3:10 P.M., Dr. Neuhauser, with Dr. Luther A. Longino, will present a paper entitled "Surgical Emergencies in Infancy and Childhood." A brief summary follows:

In this presentation, a number of important surgical emergencies will be presented. The clinical features, physical examination, roentgen findings, and emergency treatment will be described.

Dr. Neuhauser will also present a paper at 2:00 P.M., Tuesday, May 3, discussing "Cystic Fibrosis of the Pancreas (The Roentgen Manifestations and Complications)." A brief precis follows:

In this presentation, the ordinary roentgen manifestations of pancreatic fibrosis will not be discussed as these are well known, but a number of important variations of the picture as seen in young infants and the complications at this age will be discussed, as well as some of the later manifestations. Many of these patients are now living into the teens or early twenties and with increasing age, complications, many of which are based on long standing inspissation of secretions with or without secondary infection, are becoming evident. The problems of calcification of the pancreas with diabetes, cirrhosis of the liver with portal hypertension, unusual secondary pulmonary infections, and other complications will be described and illustrated.



**Lent C.
Johnson, M.D.**
Washington, D. C.

LENT C. JOHNSON, M.D., Washington, D. C., is chief of the Musculo-Skeletal Pathology Branch of the Armed Forces Institute of Pathology. Dr. Johnson received his undergraduate training and B.S. degree from the University of Chicago. His M.D. degree was also obtained from the University of Chicago.

Dr. Johnson will make a presentation on the subject "Kinetics of Osteoarthritis" on Monday, May 2, at 4:00 P.M. A summary of the paper follows:

Osteoarthritis is not a passive result of joint activity but the result of alteration of the normal remodeling of joints that goes on throughout life. The mechanism of remodeling will be discussed together with evidence for the constant turnover of cartilage, the cartilaginous source of mucin in the synovial fluid, and the continued growth of the articular cartilage throughout life. From an understanding of these mechanisms, osteoarthritis becomes much more comprehensible.

Dr. Johnson will also present a paper entitled "The General Theory of Bone Tumors" on Tuesday, May 3. A precis of the paper follows:

Bone tumors occur in specific places under specific circumstances. Consideration of the sites of origin indicates that each type of tumor arises out of a particular metabolic field. Consideration of the variations of structure within a tumor indicate that the cytology of the tumor is much more a product of the field of origin than of the cell of origin. While diagnosis is largely a matter of cytologic evaluation, prognosis is much more a matter of roentgenologic evaluation.

Curtis J.
Lund, M.D.
Rochester, N. Y.



CURTIS J. LUND, M.D., Rochester, New York, is Professor of Obstetrics and Gynecology at the University of Rochester School of Medicine and Dentistry and Obstetrician and Gynecologist in Chief at the Strong Memorial Hospital.

Dr. Lund will present a paper at 3:35 P.M., Monday, May 2, entitled "Clinical Management, Heart Disease in Pregnancy." His summary of this paper follows:

The outcome of pregnancy in a woman with organic

heart disease is determined by the favorable or unfavorable balance which exists between her cardiac reserve and the burden of pregnancy. Some of these loads are inevitable and must be recognized by the physician; others are avoidable and should be prevented.

Comparatively simple but adequate measures are available to the obstetrician for evaluation of most patients. These include the functional classification and other historical points as well as obvious diagnostic observations. The addition of a few simple laboratory studies complete the list.

Although labor is a dramatic episode psychologically for both the patient and the physician, the more hazardous period is the immediate puerperium. Recognition and treatment of impending failure at this time is most essential.

Interruption of pregnancy, cardiac surgery during pregnancy, and post partum sterilization have limited indications and are to be individually and tightly drawn. Increasing evidence supports the view that pregnancy does not alter significantly the longevity of the woman with rheumatic heart disease if she can survive the gestation.

Dr. Lund received his B.S. degree from Kansas State College and his M.S. and M.D. degrees from the University of Wisconsin. He is a member of the American Gynecological Society, American Association of Obstetricians and Gynecologists, American College of Obstetricians and Gynecologists, and is a director of the American Board of Obstetrics and Gynecology. He has made numerous contributions to the literature.

Henry K.
Beecher, M.D.
Boston, Mass.



HENRY K. BEECHER, M.D., Boston, Massachusetts, who delivered the Calhoun Lecture in Atlanta, Georgia in 1948, will present a paper at 9:40 A.M., Tuesday, May 3, entitled "The Role of the Anesthesiologist in the Injured Patient." A short summary of Dr. Beecher's paper follows:

The first responsibility in caring for the seriously injured patient is such immediate care as may be required by immediate threats to his life (an obstructed airway, gross hemorrhage) and when such like matters have been cared for, to appraise the condition of the subject and then as quickly as possible ascertain in which direction his condition is swinging, whether improved or worsening. Important guides in this will be discussed, as well as sensible indications for the determination of optimal time for the induction of anesthesia, for surgery, and support during this period. Some attention will be given to common errors in dealing

with the seriously injured patients. The choice of anesthesia for the seriously wounded will be considered.

Dr. Beecher will also present another paper entitled "Problems in Pain" at 3:10 P.M., Tuesday, May 3. A summary of this paper follows:

Here attention will be given to a relationship. Material will be presented which indicates that a quantitative approach to problems of pain and its relief is feasible and revealing. Evidence will be presented to indicate that for all practical purposes the common pain-relieving agents very quickly achieve a ceiling of effectiveness. Hazards encountered when doses exceed the optimal level will be discussed. Certain fallacies which have been derived with too close a preoccupation with experimentally produced pain will be pointed out and evidence provided to indicate that significance of a wound is more likely to determine suffering than any other common factors. Closely related to these matters are the problems of effectiveness of placebos and those who react favorably to placebos. Some discussion will be given to some of the newer analgesic agents and what they have to offer.

Dr. Beecher obtained his A.B. and M.A. degrees from the University of Kansas and his M.D. degree (cum laude) from Harvard University. He holds honorary membership in The Royal Society of Medicine, London, the American Academy of Arts and Sciences, and The Association of Anaesthetists of Great Britain and Ireland (Corresponding Fellow). He is a member of the American Society for Clinical Investigation, American Society for Thoracic Surgery, American Society of Anesthesiologists, and the American Surgical Association.

Paul G.
Reque, M.D.
Birmingham, Ala.



PAUL G. REQUE, M.D., Birmingham, Alabama, is Chief, Section of Dermatology and Syphilology, Lloyd Noland Foundation Hospital, Fairfield, Alabama, and Associate Professor, Dermatology and

Syphilology, University of Alabama School of Medicine. He obtained his undergraduate training and his M.D. degree from Duke University, where he returned on the staff as associate dermatologist. Dr. Reque is a member of several Southern and national dermatologic societies and has made several contributions to the literature.

On Sunday, May 1, at 2:30 P.M., Dr. Reque will present a paper entitled "Internal Remedies in External Diseases." A short precis of Dr. Reque's paper follows:

A brief review of the outstanding current systemic medications useful in dermatologic diseases, and principle methods of administration. Reference to especially helpful recent additions to the treatment of skin diseases will be made, with some personal observations of defects and shortcomings in some commonly used drugs.

Attention to drug reactions and their detection, dangers, and treatment of drug reactions will be discussed.

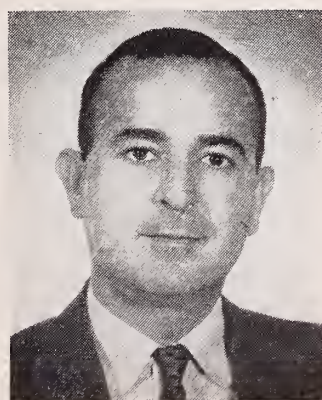
Wyland F.
Leadbetter, M.D.
Boston, Mass.



WYLAND F. LEADBETTER, M.D., Boston, Massachusetts, Chief of Urology at the Massachusetts General Hospital, will present a paper entitled "Diagnosis and Treatment of Some Pediatric Urological Problems" on Monday, May 2, at 2:30 P.M. A summary of his paper follows:

It is planned to give a discussion of the etiology of bladder neck, bladder, and ureteral dysfunctions in children; to present and illustrate diagnostic procedures which are utilized to arrive at an accurate diagnosis, and to present illustrative cases. A movie demonstrating cineradiographic cystograms and vesicoureteral reflux will be shown.

Harry
Prystowsky, M.D.
Gainesville, Fla.



HARRY PRYSTOWSKY, M.D., Gainesville, Florida, has been a Professor and Head of Obstetrics and Gynecology at the University of Florida College of Medicine since 1958. He received his M.D. degree from the Medical College of the State of South Carolina and was the Chief Resident in Ob-

stetrics at Johns Hopkins Hospital. Dr. Prystowsky will present a paper entitled "Diabetes Mellitus in Pregnancy" at 10:30 A.M., Tuesday, May 3. A summary of his paper follows:

Prior to the advent of insulin in 1921, the great majority of diabetic women were sterile. When pregnancy did occur, about one-fourth of the mothers and about half of the infants died.

The experience of this pre-insulin era is not merely of historical interest but has great clinical import. It clearly demonstrates that untreated diabetes and pregnancy are basically incompatible.

The mutual incompatibility between neglected diabetes mellitus and pregnancy demands emphasis, for only insofar as the disease process can be meticulously controlled and the metabolic disturbances curbed, can its terrible effects on the childbearing woman and her infant be forestalled.

Dr. Prystowsky is a Diplomate on the American Board of Obstetrics and Gynecology, a member of the American College of Obstetrics and Gynecology, American Federation of Clinical Research, and Johns Hopkins Medical and Surgical Association.

Luther A.
Longino, M.D.
Boston, Mass.



LUTHER A. LONGINO, M.D., Boston, Massachusetts, is a surgeon at Children's Hospital in Boston and is a clinical associate in surgery at Harvard Medical School. He received his M.D. degree from the University of Arkansas School of Medicine.

Dr. Longino is a Fellow of the American College of Surgeons, a Diplomate of the American Board of Surgery, and an Affiliate in Surgery of the American Academy of Pediatrics.

An address entitled "Diagnosis and Surgical Management of Esophageal Lesions in Children" will be presented by Dr. Longino at 3:00 P.M., Sunday, May 1. A summary of the paper follows:

Esophageal lesions in children can be divided into congenital and acquired types. The most common congenital type being esophageal atresia with or without an associated tracheo-esophageal fistula. The acquired lesions will include caustic burns, peptic esophagitis, and esophageal varices.

The above lesions will be dealt with in relation to emergency surgical procedures and the long term care of these children. Total and partial replacement of the esophagus with a segment of colon will also be discussed.

Dr. Longino will also present a paper jointly with Dr. Edward B. D. Neuhauser of Boston at 3:10 P.M., Monday, May 2, entitled "Surgical Emergencies in Infancy and Childhood."

Leslie V.
Dill, M.D.
Washington, D. C.



LESLIE V. DILL, M.D., Washington, D.C., is Assistant Clinical Professor, Obstetrics and Gynecology, Georgetown University School of Medicine and Consultant, Obstetrics and Gynecology to the Surgeon General, Walter Reed Army Medical Center, Washington, D. C.

At 4:15 P.M., Monday, May 2, Dr. Dill will present a paper entitled "Modern Concepts in Prenatal Care." A brief summary of his paper follows:

In recent years the care of the pregnant woman has deteriorated into the unimaginative filling-in of a multiplicity of history forms, examination sheets, irrelevant laboratory blanks, and blood pressure curves. To the patient has been given the responsibility of reading do-it-yourself books on diet, relaxation, and the control of the bodily and spiritual functions during pregnancy. It is not surprising that such a program has not materially altered the fetal mortality; it is cause for concern that the concept of prophylactic obstetrics has been allowed to follow this path.

The evaluation of the obstetrical patient at her first visit and the changes that call for dynamic reappraisal with the progression of the pregnancy are emphasized.

Most complications of pregnancy are preventable; few are not amenable to therapy; none are unforeseeable.

Dr. Dill received his B.S. and M.D. degrees from Duke University. He is a Diplomate of the American Board of Obstetrics and Gynecology and a Fellow of the American College of Surgeons. He has made recent contributions to the literature.

Visit the Commercial Exhibits.

These Exhibits make your Convention possible!



George J.
Curry, M.D.
Flint, Mich.

GEORGE J. CURRY, M.D., Flint, Michigan, is Chief Consultant, Section for the Surgery of Trauma, Hurley Hospital in Flint. He is a Fellow of the American College of Surgeons; member of the Board of Governors of the American College of Surgeons; Fellow of the American Association for the Surgery of Trauma, and past chairman of the Subcommittee on Transportation of the Injured, Committee on Trauma, American College of Surgeons.

On Monday, May 2, at 9:30 A.M., Dr. Curry will present a paper entitled "Responsibility to the In-

jured." A summary of his paper follows:

In this paper the following items will be discussed:

1. The adoption of a city ordinance requiring certificates of proficiency for ambulance attendants.
2. Educational programs for ambulance attendants in each community, sponsored by the county medical societies, local regional committees on trauma of the American College of Surgeons, and hospital staff organizations.
3. A receiving department chart of cases admitted to record the quality of the transportation used.
4. Inspection of ambulance equipment twice yearly.
5. A well-organized emergency receiving department and efficient organization for hospital care.
6. The entire story placed in the hands of the proper individuals who will work.

Dr. Curry will also present another paper at 10:30 A.M., Tuesday, May 3, entitled "The Immediate Treatment of Multiple Injuries to the Lower Extremities" and a summary of that paper now follows:

The immediate treatment of any lower extremity injury, irrespective of hard or soft tissue involvement, begins, as implied, at the time of the injury. Tissue healing begins the first minute following any injury; therefore, immediate care may be defined as the first phase of definitive care or in reality, *definitive care*. Soft tissue involvement, may include severed arterial mainstems, severed or traumatized nerves and muscle damage in addition to all types, numbers, levels, and degrees of osseous damage. The objective becomes a matter of the saving of life and limb; severe hemorrhage producing the former and vascular damage the hazard and real producer of the latter.



Franklin B.
Peck, Sr., M.D.
Indianapolis, Ind.

FRANKLIN B. PECK, SR., M.D., Indianapolis, Indiana, is the Director of Clinical Research International Division, Lilly Research Laboratories. He will present a paper at 10:00 A.M., Tuesday, May 3, entitled "Clinical Use of Insulin." A summary of this paper follows:

Modern therapy has been based on compensating the diabetic imbalance brought about by extra demands on the

insulogenic mechanism by means of insulin artificially introduced into the system or reducing the stress load by dietary restriction. The recent introduction of oral hypoglycemic agents has introduced special problems which are not yet resolved. The diet is every bit as important a part of treatment as the prescription of insulin or oral tablets but this keystone of therapy is being sadly neglected.

Today most clinicians *aim* as closely as possible toward the establishment of normal blood chemistry and freedom from glycosuria, but *accept* partial fulfillment of these objectives. Such a compromise usually permits glycosuria in one period after a meal, a blood sugar higher than normal on one post-prandial period, normal cholesterol values, absence of urinary ketones, and normal activity weight and growth without hypoglycemic reactions.

The place of oral agents in therapy will be considered along with a discussion of the clinical principles involved in the use of the several varieties of modified insulin preparations in relation to their differences in time action.

Dr. Peck is a Fellow of the American College of Physicians, past president of the Indianapolis Clinical Diabetes Society, first vice president of the American Diabetes Association, Associate Professor of Medicine at the Indiana University School of Medicine, and Consultant for the Department of Medicine at Indianapolis General Hospital.

The Program

SUNDAY AFTERNOON, MAY 1

Social Events

(Not a part of Official Program)

Sunday Noon, May 1

NOTE: Make reservations in advance with chairman if possible.

12:00 Georgia Society of Dermatologists Social and Luncheon
1918 Country Club Road
Dave Berman, Columbus, Chairman

2:00 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)

Municipal Auditorium

PRESIDING

Luther Wolff, Columbus, President

NOMINATION OF OFFICERS AND COUNCILORS

(Announcement of Tellers Committee)

President-Elect

First Vice President

Second Vice President

Secretary

AMA Delegate (Term beginning January 1, 1961)

AMA Alternate Delegate (Term beginning January 1, 1961)

AMA Delegate (Term beginning January 1, 1961)

AMA Alternate Delegate (Term beginning January 1, 1961)

Ninth District Councilor

Ninth District Vice Councilor

Tenth District Councilor

Tenth District Vice Councilor

NOMINATIONS FOR AWARDS

GENERAL PRACTITIONER OF THE YEAR AWARD

(To be voted on by the House of Delegates)

HARDMAN AWARD

(To be voted on by the House of Delegates)

2:30 Radiology, Pediatrics, Orthopedics, Surgery and Neurological Surgery Joint Section Meeting

(ALL PHYSICIANS INVITED)

Municipal Auditorium

PRESIDING

Mercer Blanchard, Columbus

2:30 LESIONS OF THE NEURO-ENTERIC CANAL
Edward B. D. Neuhauser, Boston, Mass.

3:00 INDICATIONS FOR EARLY SURGERY IN CEREBRAL PALSY

Lenox D. Baker, Durham, N. C.

3:30 DIAGNOSIS AND SURGICAL MANAGEMENT OF ESOPHAGEAL LESIONS IN CHILDREN

Luther Longino, Boston, Mass.

4:00 TREATMENT OF HYDROCEPHALUS

George Smith, Augusta

4:20 SURGICAL TREATMENT OF CONGENITAL HEART DISEASE IN INFANCY

Robert G. Ellison, David P. Hall, and

A. Calhoun Witham, Augusta

4:40 STAPHYLOCOCCAL INFECTIONS IN HOSPITALS AND IN THE COMMUNITY

Andre J. Nahmias, Chamblee

2:30 General Practice and EENT Joint Section Meeting

(ALL PHYSICIANS INVITED)

PRESIDING

C. Denton Johnson, Columbus

2:30 INTERNAL REMEDIES IN EXTERNAL DISEASES

Paul G. Reque, Birmingham, Ala.

3:00 THE INTRACTABLE COUGH OF ALLERGIC ORIGIN

Carl C. Jones and Clarence L. Laws, Atlanta

3:20 INTERMISSION

PRESIDING

Floyd C. Jarrell, Jr., Columbus

3:30 FOUR YEARS EXPERIENCE WITH FENESTRATION OF THE OVAL WINDOW

John J. Shea, Jr., Memphis, Tenn.

4:15 ASPIRATION TREATMENT OF PERITONSILLAR ABSCESS

James T. King, Atlanta

4:30 SIMPLIFICATION OF CATARACT TECHNIQUE

John R. Fair, Augusta

4:45 MAG Delegates Registration

Municipal Auditorium Meeting Hall Entrance

5:05 House of Delegates Meeting

Municipal Auditorium

PRESIDING

Thomas W. Goodwin, Augusta,
Speaker of the House

5:05 ORDER OF BUSINESS (*See Delegate's Handbook*)

REPORT OF PRESIDENT WOMAN'S AUXILIARY TO MAG

Mrs. Remer Y. Clark, Marietta

SUNDAY NIGHT, MAY 1

Social Events

(Not a part of Official Program)

Sunday Night, May 1

NOTE: Make reservations in advance with chairman if possible.

- 6:00 Georgia Society of Ophthalmology and Otolaryngology Dinner
Columbus Country Club
Floyd C. Jarrell, Jr., Columbus, Chairman
- 6:00 Georgia Radiological Society Social Hour and Dance
Ralston Hotel
George Hutto, Columbus, Chairman
- 6:30 Georgia Pediatric Society Social Hour and Dinner
Columbus Country Club
Mercer Blanchard, Columbus, Chairman
- 7:00 Georgia Psychiatric Association Dinner
Columbus Country Club
Luther J. Smith, II, Columbus, Chairman

8:30 MAG General Session

(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)

Royal Theater

PRESIDING

Luther H. Wolff, Columbus, President,
Medical Association of Georgia

- 8:35 DR. A. C. HOBBS MEMORIAL CONCERT
COLUMBUS CITY SYMPHONY ORCHESTRA
Robert M. Barr, Conductor

- 9:00 ADDRESS: YOUR STATE GOVERNMENT AND
THE MEDICAL PROFESSION
Hon. S. Ernest Vandiver, Governor,
State of Georgia

MONDAY MORNING, MAY 2

8:00 MAG Reference Committees

- 8:00 REFERENCE COMMITTEE NO. 1
Room 710, Ralston Hotel
- 8:00 REFERENCE COMMITTEE NO. 2
Room 630, Ralston Hotel
- 8:00 REFERENCE COMMITTEE NO. 3
Ralston Hotel (See Hotel Bulletin Board)

9:00 General Session (G.P. Day)

(ALL PHYSICIANS INVITED)

Municipal Auditorium

PRESIDING

Ben K. Looper, Canton

- 9:00 THE \$5.00 INTERVIEW FOR THE OLDER
NEUROTIC PATIENT
John Warkentin, Atlanta, and
Leonard T. Maholick, Columbus

- 9:30 RESPONSIBILITY TO THE INJURED
George J. Curry, Flint, Mich.

- 10:00 PANEL: TRAFFIC INJURIES
MODERATOR
Julian K. Quattlebaum, Savannah
PANELISTS:
Robert Major, Augusta
Edgar Fincher, Atlanta
J. P. Woodhall, Macon
George J. Curry, Flint, Mich.
Wyland F. Leadbetter, Boston, Mass.

- 11:15 MENTAL HEALTH PLANS FOR GEORGIA
Irville H. MacKinnon, Milledgeville

9:00 Georgia Radiological Society Business Meeting and Roentgen Interpretation Session

Navy Building Auditorium

PRESIDING

Bert Malone, Brunswick

- 9:00 BUSINESS MEETING

- 10:30 PANEL: ROENTGEN INTERPRETATION
SESSION

MODERATOR

Ted F. Leigh, Atlanta

PANELISTS:

Col. Edward M. DeYoung, Ft. Benning
Robert Tankesley, Atlanta
James V. Rogers, Jr., Atlanta
Edward B. D. Neuhauser, Boston, Mass.

12:00 MAG General Session Continued (Business)

(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)

PRESIDING

Luther H. Wolff, Columbus, President,
Medical Association of Georgia

- 12:00 INVOCATION

- 12:05 WELCOME

Simone Brocato, Columbus, President,
Muscogee County Medical Society
Hon. B. Ed. Johnson, Mayor of Columbus

PRESIDING

Corbett Thigpen, Augusta,
First Vice President

REPORT OF THE PRESIDENTIAL YEAR
1959-1960

Luther H. Wolff, Columbus, President

THE ASSOCIATION FUTURE, 1960-1961

Milford B. Hatcher, Macon, President-Elect

- 1:00 MAG INDOCTRINATION LUNCHEON FOR
NEW MEMBERS

Ambassador Restaurant

PRESIDING

Luther H. Wolff, Columbus, President

MONDAY AFTERNOON, MAY 2

Social Events

(Not a part of Official Program)

Monday Afternoon, May 2

NOTE: Make reservations in advance with chairman if possible.

12:30 Georgia Society of Internal Medicine Luncheon

Martinique Motel

John K. Davidson, Columbus, Chairman

1:00 Georgia Urological Society Luncheon
Ralston Hotel

Franklin D. Edwards, Columbus, Chairman

1:00 Georgia Academy of General Practice Luncheon

Holiday Inn

C. Denton Johnson, Columbus, Chairman

1:00 Georgia Radiological Society Luncheon
Holiday Inn

George Hutto, Columbus, Chairman

2:30 MAG Reference Committees

2:30 REFERENCE COMMITTEE No. 4
Room 710, Ralston Hotel

2:30 REFERENCE COMMITTEE No. 5
Room 630, Ralston Hotel

2:30 Pediatrics and Radiology Joint Section Meeting

(ALL PHYSICIANS INVITED)

Navy Building Auditorium

PRESIDING

George Hutto, Columbus

2:30 RETROGRADE UROGRAPHY IN CHILDREN
Robert Tankesley, Atlanta

2:50 PLACENTA VISUALIZATION
Robert Quattlebaum, Atlanta

3:10 SURGICAL EMERGENCIES IN INFANCY AND CHILDHOOD
Edward B. D. Neuhauser and
Luther A. Longino, Boston, Mass.

4:15 THE PROCESS OF REFERRAL FOR PSYCHI-
ATRIC CONSULTATION IN PEDIATRIC
PRACTICE
William H. Kiser, Atlanta

4:35 USING OUR RESOURCES IN HELPING
CHILDREN
William E. Laupus, Augusta

2:30 Obstetrics and Gynecology, Medicine and General Practice Joint Section Meeting

(ALL PHYSICIANS INVITED)

Municipal Auditorium

PRESIDING

Walter G. Thwaite, Columbus

2:30 POST-PARTAL HEART DISEASE
Simone Brocato, Columbus

2:50 PHYSIOLOGICAL CHANGES IN THE CARDIO-
VASCULAR SYSTEM DURING PREGNANCY
Paul Winchell, Minneapolis, Minn.

3:35 THE OBSTETRICAL MANAGEMENT OF THE
PREGNANT CARDIAC
Curtis J. Lund, Rochester, N. Y.

4:15 MODERN CONCEPTS IN PRENATAL CARE
Leslie V. Dill, Washington, D. C.

2:30 Orthopedic and Pathology Joint Section Meeting

Martin Army Hospital, Ft. Benning

2:30 ORTHOPEDIC CONFERENCE
Col. Ernst Dehne, Ft. Benning

4:00 OSTEOARTHRITIS
Lent C. Johnson, Washington, D. C.

4:45 BONE PATHOLOGY CONFERENCE
Lent C. Johnson, Washington, D. C. and
Col. Ernst Dehne, Ft. Benning

2:30 Urology Section Meeting

Navy Building Classroom

PRESIDING

R. W. McAllister, Macon

2:30 DIAGNOSIS AND TREATMENT OF SOME
PEDIATRIC UROLOGICAL PROBLEMS
Wyland F. Leadbetter, Boston, Mass.

3:15 PYELOGRAPHIC CLINIC
MODERATOR
Wyland F. Leadbetter, Boston, Mass.

4:00 Neurological Surgery Organizational Meeting

Navy Building Classroom

PRESIDING

Edgar F. Fincher, Atlanta

4:00 BUSINESS SESSION

MONDAY NIGHT, MAY 2

Social Events

(Not a part of Official Program)

Monday Night, May 2

NOTE: Make reservations in advance with chairman if possible.

- 6:30 Medical College of Georgia Alumni
Social Hour
Columbus Country Club
Roy Gibson, Columbus, Chairman
- 8:00 Medical College of Georgia Alumni Dinner
Columbus Country Club
Roy Gibson, Columbus, Chairman
- 9:00 Muscogee County Medical Society Open House
to
(Dutch Treat Refreshments—Orchestra—
1:00 Bridge Tournament, *Standard Club*)
Columbus Country Club
Henry Boyter, Columbus, Chairman

TUESDAY MORNING, MAY 3

9:00 Obstetrics and Gynecology, Medicine, Diabetes and Dermatology Joint Section Meeting

(ALL PHYSICIANS INVITED)

Municipal Auditorium

PRESIDING

Guy J. Dillard, Columbus

- 9:00 DIABETIC NEUROPATHY
Harry H. Brill, Columbus
- 9:15 SKIN MANIFESTATIONS IN DIABETES
Herbert S. Alden, Atlanta
- 9:30 MEDICAL MANAGEMENT OF HEART DISEASE
DURING PREGNANCY
Paul Winchell, Minneapolis, Minn.
- 10:00 CLINICAL USE OF INSULIN
Franklin B. Peck, Sr., Indianapolis, Ind.
- 10:30 DIABETES MELLITUS IN PREGNANCY
Harry Prystowsky, Gainesville, Fla.
- 11:00 INTERMISSION—VIEW EXHIBITS
- 11:15 PANEL: MEDICAL COMPLICATIONS OF
PREGNANCY
MODERATOR
John K. Davidson, Columbus
- PANELISTS:
Herbert S. Alden, Atlanta
Franklin B. Peck, Sr., Indianapolis, Ind.
Harry Prystowsky, Gainesville, Fla.
Paul Winchell, Minneapolis, Minn.

9:00 Surgery, Orthopedics and Anesthesia Joint Section Meeting

(ALL PHYSICIANS INVITED)

Navy Building Auditorium

PRESIDING

Jack Hughston, Columbus

- 9:00 THE PROBLEM OF TETANUS CONTROL
John P. Wilson and A. H. Letton, Atlanta
- 9:20 TREATMENT OF BURNS OF DIFFICULT AND
PRIORITY AREAS
John A. Moncrief, Atlanta
- 9:40 THE ROLE OF THE ANESTHESIOLOGIST IN
THE INJURED PATIENT
Henry K. Beecher, Boston, Mass.
- 10:10 TRAUMATIC HINDQUARTER AMPUTATION
John McPherson, Athens
- 10:30 THE IMMEDIATE TREATMENT OF MULTIPLE
INJURIES TO THE LOWER EXTREMITIES
George J. Curry, Flint, Mich.
- 11:00 DIVERTICULITIS OF THE COLON—A STUDY
OF METHODS OF TREATMENT
A. B. Conger, Columbus
- 11:20 LOCAL GASTRIC COOLING OF MASSIVE
GASTRIC HEMORRHAGE
Owen H. Wangenstein, Minneapolis, Minn.

9:00 Pathology Section Meeting

(ALL PHYSICIANS INVITED)

Navy Building Classroom

PRESIDING

Frank Stephens, Columbus

- 9:00 BONE TUMORS
Lent C. Johnson, Washington, D. C.
- 10:15 FORENSIC PATHOLOGY: EXHUMATION
J. Robert Teabeaut, II, Augusta
- 11:00 DIVERTICULITIS OF THE COLON—A STUDY
Regene Jegier Nacheff, Columbus
- 11:30 PROLONGED FEEDING OF SIMULATED
HUMAN DIET TO RABBITS
Frank Beckel, Columbus

**Changes are always made after the
printing of the program in the Journal.
Be sure to check the Official Program
for these changes.**

TUESDAY AFTERNOON, MAY 3

Social Events

(Not a part of Official Program)

Tuesday Afternoon, May 3

NOTE: Make reservations in advance with chairman if possible.

- 12:00 Georgia Chapter, American College of Chest Physicians and Georgia Trudeau Society
Columbus Country Club
Robert H. Vaughan, Columbus, Chairman
- 12:30 Georgia Chapter, American College of Surgeons and Georgia Society of Anesthesiologists
Joint Luncheon
Martin Army Hospital Dining Room, Ft. Benning
S. A. Roddenbery, Columbus (Surgery) and George E. Donaghy, Columbus (Anesthesiology), Chairmen
- 12:30 Georgia State Obstetrical and Gynecological Society Luncheon
Ambassador Restaurant, Traffic Circle, Victory Highway, Ft. Benning Road
P. C. Graffagnino, Columbus, Chairman
- 12:30 Georgia Association of Pathologists Luncheon and Business Session
Ambassador Restaurant
Frank Beckel, Columbus, Chairman
- 1:00 Georgia Diabetes Association Luncheon
Martinique Motel
John K. Davidson, Columbus, Chairman

2:00 General Practice, Orthopedics, Radiology, Neurological Surgery and Psychiatry Joint Section Meeting

(ALL PHYSICIANS INVITED)

Municipal Auditorium

PRESIDING

Simone Brocato, Columbus

- 2:00 CYSTIC FIBROSIS OF THE PANCREAS (THE ROENTGEN MANIFESTATIONS AND COMPLICATION)
Edward B. D. Neuhauser, Boston, Mass.
- 2:30 MEDICAL ASPECT OF THE MANAGEMENT OF PATIENTS WITH STROKES
T. Sterling Claiborne, Atlanta
- 3:00 THE DIAGNOSIS AND SURGICAL TREATMENT OF EXTRACRANIAL OCCLUSIVE VASCULAR DISEASE, A COMMON CAUSE OF STROKES
Francis Murphey, Memphis, Tenn.
- 3:30 PHYSICAL REHABILITATION OF THE STROKE PATIENT
Louis P. Britt, Memphis, Tenn.
- 4:00 STROKE FROM THE PSYCHIATRISTS VIEWPOINT
Morgan E. Scott, Atlanta

2:15 Obstetrics and Gynecology Section Meeting

Ambassador Restaurant, Traffic Circle, Victory Highway, Ft. Benning, Road

PRESIDING

E. Carson Demmond, Savannah

2:15 PANEL DISCUSSION OF TOPIC PRESENTATION BELOW

MODERATOR

Hugh J. Bickerstaff, Columbus

PANELISTS:

Leslie V. Dill, Washington, D. C.

Eugene Griffin, Atlanta

Curtis P. Lund, Rochester, N. Y.

Harry Prystowsky, Gainesville, Fla.

THE ROLE OF SURGERY IN THE TREATMENT OF CA OF CERVIX

Hoke Wammock, Augusta

AMNIOTIC FLUID EMBOLISM

L. S. Bodziner, Savannah

RUPTURED UTERINE ARTERY DURING DELIVERY

Jule Neal, Macon

CL. WELCHII PERITONITIS, POST-OPERATIVE

W. D. Varner, Columbus

DUHRSSSEN'S INCISIONS

P. C. Graffagnino, Columbus

2:30 Surgery and Anesthesiology Joint Section Meeting

(ALL PHYSICIANS INVITED)

Martin Army Hospital, Ft. Benning

PRESIDING

S. A. Roddenbery, Columbus

2:30 INTESTINAL OBSTRUCTION IN THE NEW-BORN

Calder B. Clay, Macon

2:50 SURGICAL CONSIDERATIONS IN CEREBRAL ARTERIAL INSUFFICIENCY

Milton F. Bryant, Atlanta

3:10 PROBLEMS IN PAIN

Henry K. Beecher, Boston, Mass.

3:40 OPERATIVE CHOLANGIOGRAPHY—A CLINICAL EXPERIENCE

Harold S. Engler, Thomas C. Mann,

Edwin L. Brackney, and

William H. Moretz, Augusta

4:00 EXTENDED OPERATION FOR ALIMENTARY TRACT MALIGNANCY

Owen H. Wangensteen, Minneapolis, Minn.

4:30 PILONIDAL CYSTS—MISNAMED, MISUNDERSTOOD AND MISTREATED

Col. Robert M. Hardaway, Ft. Benning

WEDNESDAY MORNING, MAY 4

9:00 House of Delegates Second Meeting (Recessed)

Municipal Auditorium

PRESIDING

Thomas W. Goodwin, Augusta,
Speaker of the House

ORDER OF BUSINESS

(See Delegate's Handbook)

11:00 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS AND
GUESTS INVITED)

Municipal Auditorium

PRESIDING

Luther H. Wolff, Columbus, President,
Medical Association of Georgia

PRESENTATION OF 50 YEAR CERTIFICATES

Lee Howard, Sr., Savannah, Immediate
Past President, Medical Association
of Georgia

PRESENTATION OF SCIENTIFIC EXHIBIT AWARDS

Ted F. Leigh, Atlanta, Chairman, Scientific
Awards Committee

PRESENTATION OF GENERAL PRACTITIONER OF THE YEAR AWARD

Ben K. Looper, Canton, President, Georgia
Academy of General Practice

PRESENTATION OF MAG CERTIFICATES OF APPRECIATION

Chris J. McLoughlin, Atlanta, Secretary,
Medical Association of Georgia

PRESENTATION OF HARDMAN AWARD

Milford Hatcher, Macon, President-Elect,
Medical Association of Georgia

PRESENTATION OF MAG DISTINGUISHED SERVICE AWARD

Luther H. Wolff, Columbus, President,
Medical Association of Georgia

SELECTION OF SITE FOR ANNUAL MEETING 1961

ANNOUNCEMENT OF MAG ELECTION RE- SULTS

Chairman, Tellers Committee

INSTALLATION OF 1960-1961 OFFICERS

Luther H. Wolff, Columbus, Immediate
Past President, Medical Association
of Georgia

ADJOURNMENT OF *106TH ANNUAL SES- SION



HAVE YOU
REMEMBERED?



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SJ

Woman's Auxiliary to the Medical Association of Georgia

35th Annual Meeting

May 1-4, 1960 — Columbus

President's Invitation

MEMBERS OF THE WOMAN'S AUXILIARY to the Medical Association of Georgia, it is my privilege to extend to each of you a cordial invitation to attend the Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

Meetings are planned to increase your knowledge and interest in your organization. Entertainment is planned for your pleasure. Participation in all activities will make your stay in Columbus most worthwhile.

Mrs. Remer Y. Clark

President, Woman's Auxiliary to the
Medical Association of Georgia



Mrs. Remer Y. Clark



Mrs. Bruce Threatte

Welcome to Columbus

IN BEHALF OF THE WOMAN'S AUXILIARY to the Muscogee County Medical Society, it is a privilege to welcome you to the 35th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

Entertainment has been planned for you and we hope your visit to Columbus will be a delightful one. It will be a pleasure to assist you in any way.

Sincerely,

Mrs. Bruce Threatte

President, Woman's Auxiliary to the
Muscogee County Medical Society

ORGANIZATION

of the

Woman's Auxiliary to the Medical Association of Georgia

Officers, 1959-1960

President—Mrs. Remer Y. Clark.....Marietta
President-Elect—Mrs. W. P. Rhyne.....Albany
First Vice-President—Mrs. A. Worth Hobby.....Atlanta
Second Vice-President—Mrs. Ennis Waldemayer.....Americus
Third Vice-President—Mrs. T. A. Peterson.....Savannah
Corresponding Secretary—Mrs. E. P. Inglis.....Marietta
Recording Secretary—Mrs. Arthur M. Hendrix.....Canton
Treasurer—Mrs. George Hutto.....Columbus
Historian—Mrs. W. P. Stoner.....Sylvester
Parliamentarian—Mrs. Shelly C. Davis.....Atlanta

Advisory Committee

Virgil Williams, M.D., *Chairman*.....Griffin
Remer Y. Clark, M.D.....Marietta
W. G. Elliott, M.D.....Cuthbert
Wm. R. Dancy, M.D.....Savannah
Henry Tift, M.D.....Macon
Luther H. Wolff, M.D., *ex-officio*.....Columbus
Milford B. Hatcher, M.D., *ex-officio*.....Macon

Standing Committee Chairmen

Achievement Award—Mrs. Edgar M. Dunstan.....Decatur
Archives—Mrs. Hayward S. Phillips.....Augusta
American Medical Education Foundation—Mrs. T. E. Dupree.....Atlanta
Brawner Trophy—Mrs. Luther H. Wolff.....Columbus
Budget and Finance—Mrs. Ralph Fowler.....Marietta
Bulletin—Mrs. W. Loyd Osteen.....Savannah
Bylaws and Procedures—Mrs. C. James Roper.....Jasper
Civil Defense—Mrs. F. Kells Boland, Jr.....Atlanta
Community Service—Mrs. P. L. Williams, Jr.....Cordele
Doctor's Day—Mrs. Byron Davis.....Valdosta
Editorial (Auxiliary News)—Mrs. John Busch.....Marietta
Legislation—Mrs. Edward L. Askren, Jr.....Atlanta
Membership—Mrs. W. P. Rhyne.....Albany
Mental Health—Mrs. Rives Chalmers.....Atlanta
Program—Mrs. A. Worth Hobby.....Atlanta
Recruitment—Mrs. Ted F. Leigh.....Atlanta
Research in Romance of Medicine—Mrs. Joe Daniel.....Macon
Safety—Mrs. Louie H. Griffin.....Claxton
Scrapbook—Mrs. T. A. Peterson.....Savannah
State Handbook—Mrs. Walker L. Curtis.....College Park
Student Loan Fund—Mrs. W. L. Sheppard.....Augusta
Today's Health—Mrs. E. W. Waldemayer.....Americus

District Councilors

First—Mrs. David Robinson.....Savannah
Second—Mrs. David D. Merren.....Albany
Third—Mrs. Robert Vaughan.....Columbus
Fourth—Mrs. J. W. Chambers.....LaGrange
Fifth—Mrs. Howard Lee.....Decatur
Sixth—Mrs. Milford B. Hatcher.....Macon
Seventh—Mrs. J. Harvey Norton, Jr.....Cave Springs
Eighth—Mrs. Byron Davis.....Valdosta
Ninth—Mrs. O. C. Pittman.....Commerce
Tenth—Mrs. Ralph Wenzel.....Social Circle

Councilor, Woman's Auxiliary to the Southern Medical Association

Mrs. Stephen W. Brown.....Augusta

County Auxiliary Presidents

Baldwin (Putnam)—Mrs. Wilbur E. Baugh.....Milledgeville
Bibb (Crawford, Jones, Monroe, Twiggs, Wilkinson)—
Mrs. W. Earl Lewis.....Macon
Bulloch-Candler-Evans—Mrs. R. L. Pence.....Metter
Carroll-Douglas-Haralson—Mrs. Martin L. Johnson, Jr.....Bowden
Chatham-Georgia Medical Society (Bryan, Long, Liberty,
Effingham, McIntosh)—Mrs. John B. Rabun.....Savannah
Chattahoochee (Gwinnett, Forsyth)—Mrs. Harry Hutchins.....Buford
Chattooga—Mrs. Wm. P. Martin.....Summerville
Cherokee-Pickens—Mrs. Charles R. Andrews.....Canton
Cobb—Mrs. John M. Hodges.....Marietta
Coffee—Mrs. T. L. Parker.....Douglas
Colquitt—Mrs. J. L. Meadors.....Moultrie
Decatur-Seminole—Mrs. E. Ashby Woods.....Bainbridge
DeKalb—Mrs. John T. Leslie.....Avondale Estates
Dougherty—Mrs. Abram Goldsmith.....Albany
Elbert-Franklin-Hart—Mrs. Robert F. Sullivan.....Carnesville
Flint (Crisp, Turner, Dooley)—Mrs. C. C. Goss.....Ashburn
Floyd—Mrs. Hobart Hortman.....Rome
Fulton—Mrs. Henry E. Steadman.....Hapeville
Glynn—Mrs. Woodrow W. Payne.....Brunswick
Gordon—Mrs. J. E. Billings.....Calhoun
Habersham (Towns, White)—Mrs. F. O. Garrison.....Demorest
Hall-Lumpkin—Mrs. Hamil Murray.....Gainesville
Jackson-Barrow—Mrs. C. B. Skelton.....Winder
Muscogee—Mrs. Bruce Threatte.....Columbus

Ocmulgee (Bleckley, Dodge, Pulaski, Wilcox)—
Mrs. W. E. Coleman.....Hawkinsville
Polk—Mrs. Don Schmidt.....Cedartown
Randolph-Terrell (Stewart, Quitman)—Mrs. R. B. Martin, III.....Cuthbert
South Georgia (Lowndes, Lanier, Berrien, Cook, Clinch)—
Mrs. Lloyd L. Burns.....Valdosta
Southwest Georgia (Calhoun, Early, Baker, Clay)—
Mrs. Turner W. Rentz.....Colquitt
Spalding (Butts, Lamar, Henry, Pike)—
Mrs. John Lamar King.....Griffin
Sumter-Schley-Macon-Marion—Mrs. Schley Gatewood.....Americus
Thomas-Brooks—Mrs. Rudolph Bell.....Thomasville
Tift—Mrs. Carl Pittman, Jr.....Tifton
Troup-Heard—Mrs. John T. Mitchell.....LaGrange
Upson—Mrs. F. M. Woodall.....Thomason
Walker-Catoosa-Dade—Mrs. Thomas A. Cochran.....Ringgold
Ware (Bacon, Brantley, Camden, Charlton, Jeff Davis, Pierce)—
Mrs. W. L. Flesch.....Waycross
Washington—Mrs. F. T. McElreath.....Tennille
Wayne—Mrs. R. A. Pumpelly.....Jesup
Whitfield-Murray—Mrs. David M. Nowell.....Dalton
Worth—Mrs. J. L. Tracy, Jr.....Sylvester

Past Presidents and Conventions

Honorary Presidents for Life

Mrs. James N. Brawner, Sr., Atlanta
Mrs. Eustace A. Allen, Atlanta
1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta,
Temporary Chairman
1925—Atlanta—Mrs. James N. Brawner, Sr., Atlanta
1926—Albany—Mrs. William H. Myers, Savannah
1927—Athens—Mrs. C. W. Roberts, Atlanta
1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaffney, S. C.)
1929—Macon—Mrs. Charles C. Hinton, Macon
1930—Augusta—Mrs. Marion T. Benson, Atlanta
1931—Macon—Mrs. Charles C. Harrold, Macon
1932—Savannah—Mrs. Ralston Lattimore, Savannah
1933—Macon—Mrs. S. T. R. Revell, Louisville
1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased)
1935—Atlanta—Mrs. J. E. Penland, Waycross
1936—Savannah—Mrs. Ernest R. Harris, Winder
1937—Macon—Mrs. W. R. Dancy, Savannah
1938—Augusta—Mrs. Ralph Chaney, Augusta
1939—Atlanta—Mrs. Warren A. Coleman, Eastman
1940—Savannah—Mrs. Eustace A. Allen, Atlanta
1941—Macon—Mrs. H. G. Bannister, Ila
1942—Augusta—Mrs. Lee Howard, Savannah
1943—Atlanta—Mrs. J. Lon King, Macon
1944—Savannah—Mrs. Olin S. Cofer, Atlanta
1945—No convention
1946—Macon—Mrs. W. T. Randolph, Winder
1947—Augusta—Mrs. W. Bruce Schaefer, Toccoa
1948—Atlanta—Mrs. W. G. Elliott, Cuthbert
1949—Savannah—Mrs. S. A. Anderson, Atlanta
1950—Macon—Mrs. J. Harry Rogers, Atlanta
1951—Augusta—Mrs. Lehman W. Williams, Savannah
1952—Atlanta—Mrs. J. R. S. Mays, Macon
1953—Savannah—Mrs. Ralph Fowler, Marietta
1954—Macon—Mrs. Leo Smith, Waycross
1955—Augusta—Mrs. Shelley C. Davis, Atlanta
1956—Atlanta—Mrs. Robert C. Major, Augusta
1957—Savannah—Mrs. Walker L. Curtis, College Park
1958—Macon—Mrs. John L. Elliott, Savannah
1959—Augusta—Mrs. Luther Wolff, Columbus

Convention Committees

WOMAN'S AUXILIARY TO THE MUSCOGEE COUNTY MEDICAL SOCIETY

General Chairmen

Mrs. Harry Brill, *Co-Chairman*
Mrs. William Cook, *Co-Chairman*

Credential and Registration

Mrs. Harry Brill, *Co-Chairman*
Mrs. William Cook, *Co-Chairman*

Mrs. Frank Beckel
Mrs. Randolph Bradshaw
Mrs. George Donaghy
Mrs. Robert Flowers
Mrs. Roy Gibson
Mrs. Jack Hirsch
Mrs. John Mayher
Mrs. William Mayher
Mrs. John Stapleton
Mrs. Clayton Taylor
Mrs. Walter Thwaite
Mrs. Joe M. Webber
Mrs. Lionel Yoe

Executive Board Meetings

Mrs. Robert Vaughan, *Chairman*
Mrs. Clarence Butler

Decorations

Mrs. Charles Smith, *Chairman*
Mrs. Hugh Bickerstaff
Mrs. George Hutto

Display and Meeting Rooms

Mrs. James Elkins, *Chairman*
Mrs. Raymond Chipman, *Co-Chairman*
Mrs. Franklin Edwards
Mrs. Roy Waller
Mrs. Kenneth Munn

Display of Old Medical Equipment

Mrs. Lee Roy Conn, *Chairman*
Mrs. Richard Snelling, *Co-Chairman*
Mrs. Lionel Yoe

Hospitality

Mrs. Charles Denton Johnson, *Chairman*
Mrs. George Epps, *Co-Chairman*
Mrs. Joseph Chastain
Mrs. Quigg Fletcher
Mrs. Otis Gilliam
Mrs. William Frank Jenkins
Mrs. James Rhea
Mrs. Dave Varner
Mrs. Douglas Venable

Information Booth and Hostesses

Mrs. Waverly Dashiell, *Chairman*
Mrs. Harold Jarrell, *Co-Chairman*
Mrs. Lionel Bazzaza
Mrs. Simone Brocato
Mrs. Willard Cooke
Dr. Jane Rivers
Dr. Mary Schley
Mrs. George Schuessler
Mrs. Joseph Serrato
Mrs. Bertling Smith
Mrs. Frank Stephens
Mrs. P. A. Tatum
Dr. Mary Tiller
Mrs. John Walker
Mrs. Neal Willis
Mrs. James Youmans

Fashion Show

Mrs. Abe Conger, *Chairman*
Mrs. John Deaton

Luncheon

Mrs. Charles Smith, *Chairman*
Mrs. Peter Graffagnino, *Co-Chairman*
Mrs. Brent Fox
Mrs. Louis Hazourl
Mrs. Willis Jordon
Mrs. Leonard Maholick
Mrs. Bruce Newsom
Mrs. Allen Petway
Mrs. Luther Smith
Mrs. James Ward

Pages

Mrs. John Durden, *Chairman*
Mrs. Frank Beckel
Mrs. Henry Boyter
Mrs. Ocie Brannen
Mrs. Randolph Bradshaw
Mrs. John Deaton
Mrs. Polk Land
Mrs. Leon Lapides
Mrs. William Love
Mrs. Julian Sizemore
Mrs. Haywood Turner

Publicity

Mrs. Richard Snelling, *Chairman*
Mrs. Lee Roy Conn, *Co-Chairman*
Mrs. Joseph Serrato

Printing and Favors

Mrs. Leon Lapides, *Chairman*
Mrs. Jack McGee, *Co-Chairman*
Mrs. Robert Flowers
Mrs. William Love

Past Presidents' Luncheon

Mrs. Luther Wolff, *Chairman*

Tea

Mrs. Abraham Kravtin, *Chairman*
Mrs. Mercer Blanchard, *Co-Chairman*
Mrs. Arthur Berry
Mrs. Jack Davidson
Mrs. John Bush
Mrs. Richard Dodelin
Mrs. George Whatley

Tour and Transportation

Mrs. Dave Berman, *Chairman*
Mrs. Edgar Horn, *Co-Chairman*
Mrs. Mercer C. Blanchard
Mrs. Bruce Newsom
Mrs. James Rhea
Mrs. William Edward Storey

Social Hour and Banquet

Mrs. John Thompson, *Chairman*
Mrs. Luther Roberts, *Co-Chairman*
Mrs. Hugh Bickerstaff
Mrs. George Conner
Mrs. Jack Hughston
Mrs. Elisha Cain
Mrs. Guy Dillard
Mrs. Floyd Jarrell
Mrs. Roy Waller

Pledge of Loyalty

to the

Woman's Auxiliary to the

Medical Association of Georgia

I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of Georgia. I will support its activities, protect its reputation, and ever sustain its high ideals.

Collect

"Keep us, O God, from pettiness; let us be large in thought, word and deed. Let us be done with fault-finding, and leave off self-seeking. May we put away pretense, and meet each other face to face, without self-pity and without prejudice.

May we never be hasty in judgment, and always generous. Let us take time for all things; make us to grow calm, serene, gentle.

Teach us to put into action our better impulses, straightforward and unafraid. Grant that we may realize it is the little things that create differences; but in the big things of life we are one.

And, may we strive to reach and to know the great, common woman's heart of us all, and O, Lord God, let us not forget to be kind."

The Program

SUNDAY, MAY 1

11:00 Registration

to
5:00 Lobby, Hotel Ralston

1:00 Pre-Convention Executive Board Meeting—Dutch Luncheon

(For 1959-60 officers, state chairmen, district councilors, county presidents, county presidents-elect, past state

presidents, and councilor to SMA Auxiliary)

Civic Room, Hotel Ralston

PRESIDING

Mrs. Remer Y. Clark, Marietta, President

INVOCATION

Mrs. E. W. Waldemayer, Americus

PLEDGE OF LOYALTY

Mrs. J. R. S. Mays, Macon

BUSINESS SESSION

**5:05 Joint Meeting—MAG House of
Delegates and Woman's Auxiliary**

Municipal Auditorium

PRESIDING

Thomas W. Goodwin, Augusta,
Speaker of the House

ORDER OF BUSINESS (*See MAG Delegate's
Handbook*)

AUXILIARY PRESIDENT'S REPORT

Mrs. Remer Y. Clark, Marietta

8:30 MAG General Session

**(All MAG and Auxiliary Members and
Guests Invited)**

Municipal Auditorium

PRESIDING

Luther H. Wolff, Columbus, President,
Medical Association of Georgia

**8:35 Dr. A. C. Hobbs Memorial Concert,
Columbus City Symphony Orchestra**

Robert M. Barr, Conductor

**9:00 Address: Your State Government
and the Medical Profession**

Hon. S. Ernest Vandiver, Governor,
State of Georgia

MONDAY, MAY 2

8:30 Registration

to *Lobby, Hotel Ralston*
3:30

9:30 General Meeting

Mirror Ball Room, Hotel Ralston

CALL TO ORDER

Mrs. Remer Y. Clark, Marietta, President

INVOCATION

Mrs. James N. Brawner, Sr., Atlanta

PLEDGE OF LOYALTY

Mrs. Ralph Fowler, Marietta

WELCOME

Mrs. Bruce Threatte, Columbus, President,
Woman's Auxiliary to the Muscogee
County Medical Society

RESPONSE

Mrs. Ted F. Leigh, Atlanta

INTRODUCTION OF HONOR GUESTS AND

PAST STATE PRESIDENTS

Mrs. Luther H. Wolff, Columbus

PRESENTATION OF CONVENTION PLANS

Mrs. Harry Brill, Columbus,
General Co-chairman

INTRODUCTION OF PAGES FOR DAY

Mrs. William Cook, Columbus,
General Co-chairman

**REPORT OF ADVISORY COMMITTEE TO
THE WOMAN'S AUXILIARY TO MAG**

Virgil Williams, M.D., Griffin, Chairman

GREETINGS

Luther H. Wolff, M.D., Columbus,
President, MAG

Milford Hatcher, M.D., Macon,
President-elect, MAG

INTRODUCTION OF GUEST SPEAKER

Mrs. Shelly C. Davis, Atlanta,
Parliamentarian

ADDRESS

Mrs. Frank Gastineau, Indianapolis, Ind.,
President, Woman's Auxiliary to the
American Medical Association

Business Session

CONVENTION RULES OF ORDER

Mrs. Shelly C. Davis, Atlanta,
Parliamentarian

ROLL CALL

MINUTES

Mrs. Arthur M. Hendrix, Canton,
Secretary

REPORTS:

PRESIDENT

Mrs. Remer Y. Clark, Marietta

PRESIDENT-ELECT

Mrs. W. P. Rhyne, Albany

TREASURER (*Including report of Auditor*)

Mrs. George Hutto, Columbus

ADDENDUM REPORTS:

COMPLETE REPORTS (*See 1959-60
Annual Report*)

RECOMMENDATIONS OF EXECUTIVE BOARD

REVISIONS

Mrs. C. James Roper, Jasper, Chairman

REPORT OF CREDENTIALS COMMITTEE

Mrs. Harry Brill, Columbus

MEMORIAL SERVICE

Mrs. David Wells, Dalton

ANNOUNCEMENTS

ADJOURNMENT

12:30 Dutch Luncheon

**(For past presidents of Woman's
Auxiliary to MAG)**

CHRISTIAN FELLOWSHIP ASSOCIATION
1240 Wynnnton Road

PRESIDING

Mrs. Luther Wolff, Columbus, Immediate
Past President

2:00 Tour of Tom Houston Peanut Company, Museum of Arts and Crafts
5:00 (transportation available, lobby of Ralston Hotel), Tea and Reception
 1240 Wynnton Road

RECEIVING AT TEA

Mrs. Bruce Threatte, Columbus, President,
 Muscogee County Auxiliary
 Mrs. Remer Y. Clark, Marietta, President,
 Woman's Auxiliary to MAG
 Mrs. Frank Gastineau, Indianapolis, Ind.,
 President, Woman's Auxiliary to AMA
 Mrs. W. P. Rhyne, Albany, President-elect,
 Woman's Auxiliary to MAG
 Mrs. Luther H. Wolff, Columbus,
 Wife of MAG President
 Mrs. Milford Hatcher, Macon,
 Wife of President-elect
 Mrs. Harry Brill, Columbus, General
 Co-chairman of Convention
 Mrs. William Cook, Columbus, General
 Co-chairman of Convention
 Mrs. A. Kravtin, Chairman of Tea
 Mrs. Mercer Blanchard, Co-chairman of Tea

TUESDAY, MAY 3

9:00 Registration
 to
12:30 Lobby, Hotel Ralston

9:30 General Meeting
 Mirror Ball Room, Hotel Ralston

CALL TO ORDER

Mrs. Remer Y. Clark, Marietta, President

INVOCATION

PLEDGE OF LOYALTY

Mrs. John F. Busch, Marietta

INTRODUCTION OF PAGES FOR THE DAY

Mrs. William Cook, Columbus, General
 Co-chairman

ANNOUNCEMENT OF CONVENTION PLANS

Mrs. Harry Brill, Columbus, General
 Co-chairman

INTRODUCTION OF GUEST SPEAKER

Mrs. W. C. Mitchell, Smyrna

GREETINGS FROM THE WOMAN'S AUXILIARY TO THE SOUTHERN MEDICAL SOCIETY

Mrs. Walker Curtis, College Park,
 Past-President

Business Session

ROLL CALL AND MINUTES

Mrs. Arthur M. Hendrix, Canton, Secretary

REPORT OF REVISIONS COMMITTEE

Mrs. C. James Roper, Jasper, Chairman

REPORT OF BUDGET AND FINANCE COMMITTEE

Mrs. Ralph Fowler, Marietta, Chairman

REPORT OF RESOLUTIONS COMMITTEE
 REPORT OF CREDENTIALS COMMITTEE
 REPORT OF COURTESY COMMITTEE
 REPORT OF AWARDS COMMITTEE
 Achievement

Mrs. E. M. Dunstan, Decatur, Chairman
 Civil Defense

Mrs. Kels Boland, Jr., Atlanta

Doctor's Day

Mrs. Byron Davis, Valdosta, Chairman

Mrs. J. Bonar White Scrapbook

Mrs. T. A. Peterson, Savannah, Chairman
 Safety

Mrs. Louie H. Griffin, Claxton, Chairman
 Brawner Trophy for General Excellence

Mrs. Luther Wolff, Columbus, Chairman

REPORT OF NOMINATING COMMITTEE

Mrs. Luther Wolff, Columbus, Chairman

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS

Mrs. Lehman Williams, Savannah

PRESENTATION OF PRESIDENT'S

PIN AND GAVEL

Mrs. Remer Y. Clark, Marietta,
 Retiring President

INAUGURAL ADDRESS AND

ANNOUNCEMENT OF 1960-61 CHAIRMEN

Mrs. W. P. Rhyne, Albany, President

ANNOUNCEMENTS

ADJOURNMENT

1:00 Luncheon and Fashion Show
 (For All Auxiliary Convention Members)

Country Club of Columbus

PRESIDING

Mrs. Remer Y. Clark, Marietta,
 Retiring President

6:30 Muscogee County Medical Society Social Hour

Country Club of Columbus

7:30 President's Banquet, MAG

Country Club of Columbus

WEDNESDAY, MAY 4

9:00 Post Convention Executive Board Meeting—Dutch Breakfast

(For 1960-61 officers, chairmen, district councilors, county presidents, county presidents-elect, past state presidents, and councilor to SMA Auxiliary)

Civic Room, Hotel Ralston

11:30 Joint General Business Session

(All MAG and Auxiliary Members and Guests)

Municipal Auditorium

PRESIDING

Luther H. Wolff, Columbus, President,
Medical Association of Georgia

PRESENTATION OF 50-YEAR CERTIFICATES

Lee Howard, Sr., Savannah, Immediate
Past President

PRESENTATION OF SCIENTIFIC EXHIBIT

AWARDS

Ted F. Leigh, Atlanta, Chairman, Scientific
Awards Committee

PRESENTATION OF GENERAL PRACTITIONER OF THE YEAR AWARD

Ben K. Looper, Canton, President, Georgia
Academy of General Practice

PRESENTATION OF MAG CERTIFICATES OF APPRECIATION

Chris J. McLoughlin, Atlanta, Secretary,
Medical Association of Georgia

PRESENTATION OF HARDMAN AWARD

Milford B. Hatcher, Macon, President-elect,
Medical Association of Georgia

PRESENTATION OF MAG DISTINGUISHED SERVICE AWARD

Luther H. Wolff, Columbus, President,
Medical Association of Georgia

SELECTION OF SITE FOR ANNUAL

MEETING 1961

ANNOUNCEMENT OF MAG ELECTION RESULTS

Chairman, Tellers Committee

INSTALLATION OF 1960-61 OFFICERS

Luther H. Wolff, Columbus, Immediate
Past President

ADJOURNMENT OF *106TH ANNUAL SESSION

**NOTE: Tickets are available at Ticket Desk for Auxiliary Convention Members for the Tour and Tea on Monday and the Luncheon and Fashion Show on Tuesday.
Register at Ticket Desk for transportation.**

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
 2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
 3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
 4. Badges must be worn by members of the voting body during all general sessions of the convention.
 5. Delegates' privileges are not transferable.
 6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by the persons making and seconding the motion.
 7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
 8. All persons appearing on the program must be seated near the platform when the session opens.
- Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.



the association

ANNOUNCEMENTS

The forthcoming seminar of the Atlanta Society of Pathologists in conjunction with the Southeastern Region of the American College of Pathologists will be held at the Academy of Medicine, 875 West Peachtree St., N.E., Atlanta, on Sunday, April 3. The subject of the seminar will be "Gynecologic and Obstetric Pathology."

The faculty will consist of Arthur Hertig, Atlanta, Dr. Saul Gusberg, New York, and Dr. Vincent P. Collins, Houston. The morning session will consist of a discussion by Dr. Hertig of a set of study slides which have previously been made available to the participants. In the afternoon the three lecturers will discuss subjects of their own choosing in individual presentations and will combine forces for a panel, answering questions from the audience.

The seminar is open to pathologists and physicians in allied fields and only those who desire slides will pay a fee of \$10.00. The meeting is in part financed by the American Cancer Society, Georgia Division. Applications and inquiries should be addressed to: Dr. Heinz Bauer, Associate Professor of Pathology, Emory University School of Medicine, Atlanta 22.

DEATHS

EGBERT CLEVELAND BRIDGES, of Donalsonville, died at the age of 73 on January 29 after a short illness.

Dr. Bridges received his Medical Degree from the Louisville Medical College, Louisville, Ky., and had practiced medicine for 52 years.

Survivors include his wife; three sons, Herbert Bridges and Champ Bridges of Donalsonville, and Charles Bridges of Bainbridge; two daughters, Mrs. Carlton Sawyer, Houston, Texas and Mrs. T. D. Tyson, Donalsonville; two sisters, Mrs. Emma Dozier, Damascus and Mrs. Nettie Coachman, Tampa, Fla.; and 18 grandchildren.

MARVIN L. GREENE, 35, of Monticello, died February 4 after an extended illness.

Dr. Greene was a native of Perry and had lived in Monticello since 1951. He became associated with Dr. J. H. Pritchett, Jr. in 1952.

He was a graduate of Mercer University and the

Medical College of Georgia. He was president of the Jasper County Medical Society, a member of the Presbyterian Church, and a director in the Kiwanis Club.

Dr. Greene was also a director of the Monticello-Jasper County Junior Chamber of Commerce, a member of the Monticello Housing Authority, Jasper County Board of Welfare, and the Monticello Chamber of Commerce.

Survivors include his parents, Mr. and Mrs. F. M. Greene, of Perry; three brothers, F. M. Greene, Jr., of Perry, Derrell Greene of Rome, and the Rev. Robert Greene of Weston, Conn.; and three sisters, Mrs. Ken Sellers of Albany, Mrs. Ben Newberry and Mrs. Hobert Richards, both of Perry.

T. E. ROGERS, SR., died January 19 at the age of 73 at his home in Macon.

Dr. Rogers was born in Cumming and was a graduate of Young Harris College and Emory University School of Medicine. He was a member of the American Medical Association, American College of Physicians, Medical Association of Georgia, Sixth District Medical Association, the Bibb County Medical Society, of which he was past president, honorary member of the Macon Rotary Club, a member of Macon Lodge 5 of Free and Accepted Masons, and an honorary member of the Macon Hospital staff.

Survivors include one son, T. E. Rogers, Jr., of Macon; one daughter, Miss Hazel Rogers of Macon; three brothers, L. L. Rogers, Winder, Henry C. Rogers, Stamford, Texas, and M. E. Rogers of Atlanta.

SOCIETIES

The COBB COUNTY MEDICAL SOCIETY and the Woman's Auxiliary held a joint meeting recently at the Marietta Country Club.

Over a thousand Southeastern physicians met in Atlanta in February for the Atlanta Graduate Medical Assembly, sponsored annually by the FULTON COUNTY MEDICAL SOCIETY.

The WARE COUNTY MEDICAL SOCIETY were recently guests of the Satilla Area Dental Society at a supper meeting at the Cherokee Restaurant.

M. C. Adair was elected to serve as president for 1960 of the WILKES COUNTY MEDICAL SOCIETY at a recent meeting. Tom Nash was elected vice-president and Wilbur Harper was elected secretary-treasurer.

The **FOURTH DISTRICT MEDICAL SOCIETY** met in January at the Elk's Club in Griffin. An afternoon scientific session was presented by A. S. Fitzhugh, J. W. Landham, and John E. Steinhaus, Professor and Chairman of the Department of Anesthesiology, Grady Memorial Hospital, Atlanta. Doctors and their wives were invited to the evening session. After dinner, Dr. Steinhaus spoke on "The Story of Resuscitation."

PERSONALS

First District

At the annual meeting of the Board of Directors of the Physicians Service Association held recently, L. M. FREEMAN, Savannah, was re-elected president.

FENWICK T. NICHOLS, JR., Savannah, was recently guest speaker at a meeting of the Emanuel County Heart Council held in Swainsboro.

Second District

CARL S. PITTMAN, SR., of Tifton, has recently been re-elected to a three year term as a director of Physicians Service, Inc., an organization connected with Blue Cross-Blue Shield Hospital Insurance.

Third District

R. C. PENDERGRASS, Americus, who has made a study of Andersonville, recently was guest speaker at the meeting of the Woman's Literary Club.

Announcement is made by JAY GOLDSTEIN and M. V. ANDERS of Warner Robins of the removal of their offices to the new Medical Center Building located on Hospital Road.

Fourth District

CURRAN S. EASLEY, JR., LaGrange, recently spoke on "Nutrition in Relation to Child Growth" at a study course on nutrition for adults held at the Rosemont Elementary School.

GEORGE L. WALKER, Griffin, has recently been re-elected president of the Griffin Hospital Care Association.

BEN H. JENKINS, Newnan, recently presented a joint scientific exhibit at the Pan-American Congress of Ophthalmology, which was held in Carracas, Venezuela.

A. H. FRYE, JR. has returned to Griffin to open his office after completing his residency at Erlanger Hospital, Chattanooga, Tenn.

ALEX JONES of Griffin was recently the principal speaker at meetings of the Kiwanis Club, the Lions Club, the Kiwanianne Club, and the Junior High School, all in Griffin.

Fifth District

MORGAN B. RAIFORD, Atlanta, recently presented a joint scientific exhibit at the Pan-American Congress of Ophthalmology, which was held in Carracas, Venezuela.

GUY V. RICE, Atlanta, spoke on "Mental Health"

at the January meeting of the DeKalb County Medical Society, Woman's Auxiliary.

A paper on "Laryngeal Trauma" was presented by TRUETT V. BENNETT of Atlanta, to the Southern Section of the American Laryngological, Rhinological, and Otological Society, which met in New Orleans in January.

A gift has been presented to the Emory University School of Medicine to establish a professorship in ophthalmology in honor of F. PHINIZY CALHOUN of Atlanta.

WILLIAM A. HOPKINS, Atlanta, recently addressed the Columbus Area TB Association.

BERNARD C. HOLLAND, Atlanta, has written a series of articles as a public service to better acquaint the public with psychiatry and mental health problems and these articles have been appearing in the Atlanta Constitution.

Five Atlanta physicians who have been members of the Fulton County Medical Society for more than 50 years were recently honored at the 55th anniversary banquet of the society. They are: H. M. S. ADAMS, GEORGE F. KLUGH, STEPHEN C. REDD, DAN Y. SAGE, and COSBY SWANSON.

WINSTON E. BURDINE, Atlanta, recently spoke to the Bainbridge Rotary Club.

SIDNEY OLANSKY of the Department of Medicine of Emory University has been elected to the Board of Directors of the American Academy of Dermatology and Syphilology.

Sixth District

Recently FRANK M. HOUSER, Macon, was presented an award by the Junior Woman's Club of Macon for outstanding services toward community betterment.

JOHN A. BELL, JR., Dublin, announces the opening of his new offices in the Dublin Medical Arts Center.

F. CLEVELAND DAVIS, Gray, has announced the opening of his office in Macon.

Seventh District

J. LEROY RABB, Calhoun, has been elected chief of the medical staff of Gordon County Hospital. CHARLES K. RICHARDS, Calhoun, was named vice chief of staff and BYRON H. STEELE, Fairmount, was elected secretary.

CHARLES G. ROGERS, Rockmart, addressed the Kiwanis Club recently and showed a film on "Strokes." The meeting was held at the Wayside Inn in Rockmart.

JAMES A. REDFEARN, JR. of Dalton, has been elected president of Hamilton Memorial Hospital Medical Staff. A. M. BOOZER was named the new vice-president and D. M. NOWELL was elected secretary.

WEBSTER ARMOUR SHERRER, Marietta, recently passed his examinations in Clinical Pathology for certification by the American Board of Pathology.

Eighth District

IVEY JACOBS, Waycross, has been admitted to the Holstein-Friesian Association, one of the world's largest dairy cattle registry organizations.

Honorary life membership in the American Social Health Association was recently given to MILLARD E. WINCHESTER, district public health director in Glynn, Camden, and McIntosh counties, at a luncheon meeting of the Georgia Social Hygiene Council at the Capitol City Club in Atlanta.

Ninth District

JOSEPH L. GRIFFETH, Commerce, recently discussed heart diseases at the meetings of two Commerce civic clubs.

CLAUDE H. BENNETT of the Toccoa Clinic was approved as a consultant in pediatrics to the Habersham County Hospital at a recent meeting of the Habersham County Medical Staff. Dr. Bennett also recently completed all requirements of the American Board of Pediatrics and is now a certified specialist in pediatrics.

CHARLES M. HENRY, Clarkesville, is now an associate of the Toccoa Clinic.

Tenth District

A. W. SIMPSON, JR., Washington, was recently guest speaker at a meeting of the Stillwell PTA.

PERRY P. VOLPITTO, chairman of the Department of Anesthesiology at the Medical College of Georgia, was recently elected president-elect of the Association of University Anesthesiologists at the national meeting of this organization held in Augusta. Dr. Volpittto was also in charge of all arrangements for this meeting.

BILLIE LAMOTTE has opened offices in Augusta for the practice of radiology.

GEORGE F. MCINNES of the Medical College of Georgia, was guest speaker at the January meeting of the Aiken, S. C. Town and Country Club.

EXECUTIVE COMMITTEE OF COUNCIL

THE MEETING OF THE Executive Committee of Council of the Medical Association of Georgia was called to order by Chairman Luther Wolff at 11:15 A.M. on January 10, 1960 in the Association Headquarters Office, Academy of Medicine, Atlanta, Georgia.

Members of the Executive Committee of Council present included: Luther H. Wolff, Columbus, President; Milford B. Hatcher, Macon, President-Elect; Chris J. McLoughlin, Atlanta, Secretary; J. G. McDaniel, Atlanta, Chairman of Council and Virgil Williams, Griffin, Chairman of Finance.

Guests present at this meeting included: Fred Simonton, Chickamauga and John Mauldin, Atlanta. Also present were Messrs. M. D. Krueger and John F. Kiser, Atlanta, Headquarters Office Staff.

Chairman Wolff called on Mr. Krueger who reviewed the minutes of the meeting of the Council of the Medical Association of Georgia held December 12-13, 1959 and who then read

the minutes of the Executive Committee of Council meeting held December 13, 1959. On motion duly made and seconded, the minutes of the Executive Committee of Council meeting December 13, 1959 were approved as read.

FULTON COUNTY MEMENTO

Chairman of Council J. G. McDaniel reported on the progress in the selection of a memento for the Fulton County Medical Society in appreciation of the Society having made quarters available to the State Medical Association over the many past years. Dr. McDaniel stated that the selection of this memento was in progress as authorized by Council.

NATIONAL FOUNDATION SCHOLARSHIP REQUEST

A communication of December 29, 1959 from the National Foundation addressed to Dr. Luther Wolff, was read. This communication requested assistance of the Medical Association of Georgia in the administration of the National Foundation's Health Scholarship Program. Specifically, the National Foundation requested that the MAG nominate three physicians for a state selection committee from whom one will be invited to serve on this committee. Council members reviewed the action of the Council on this same matter in 1959 at which time such a request was rejected. On motion (Williams-Hatcher) it was voted to write a letter similar to the 1959 letter to the National Foundation, giving the Council's reasons why this request be rejected. The motion further stated that Dr. Wolff as President notify the National Foundation of this action.

INTERPROFESSIONAL COUNCIL APPOINTMENT

Secretary Chris J. McLoughlin informed the Executive Committee of Council of the expiration of office of the MAG representative on the Interprofessional Council. President Wolff then reappointed the present representative of the Association for a term of three years on the Interprofessional Council. The MAG representative so appointed is Dr. Chris J. McLoughlin.

MAG JOURNAL FOR AMA DELEGATES

At the last Council meeting Mr. Krueger was charged with the responsibility of ascertaining the cost of sending the *Journal of the Medical Association of Georgia* to the AMA Delegates. Mr. Krueger reported that there would be no printing charge for an additional 200 copies monthly of the *Journal* and that plates for addressing the *Journal* would cost approximately \$25.00; mailing per year approximately \$48.00; and envelopes per year approximately \$20-\$25. On motion (McDaniel-Williams) it was voted to send the *Journal of the Medical Association of Georgia* to the AMA Delegates for the approximate cost to the Association of \$100 per year to be charged to the *Journal* and the motion further stated that the MAG-AMA Delegates transmit a letter to the AMA Delegates informing them of this complimentary subscription to the *JMAG*.

HEADQUARTERS OFFICE REPORT

Mr. Krueger reported on the status and activity of the Headquarters Office personnel. In particular, discussion arose about the employment of a secretary for Mr. Krueger and Mr. Kiser. By general agreement, this matter was deferred until the February meeting of the Executive Committee.

LEGISLATIVE COMMITTEE REPORT

Mr. John Kiser reported for Dr. J. Frank Walker on the status of state legislation. Mr. Kiser also reported on the activity of the MAG and the AMA on national legislative matters and he outlined the status at the present on the Forand bill.

OTHER BUSINESS

Fred Simonton discussed the recommendation that a psychiatrist be added to the State Board of Health. After some discussion of this matter, on motion (Hatcher-McDaniel) it was voted that Executive Committee of Council approve in principal the Governor's Economy Committee recommendation that a psychiatrist be added to the Board of Health and further that this psychiatrist be chosen by the Governor from two names submitted to the Governor for this position by the Medical Association of Georgia. The motion further advised the MAG Leg-

islative Committee to closely follow legislative action on this matter.

BLOOD TESTS

Members of the Executive Committee of Council discussed the proposed repeal of the Blood Test Act as requested by Dr. Venable through the Auxiliary to the MAG at the December 12-13 meeting of the Council. It had been asked that the Auxiliary to the Medical Association of Georgia aid and assist in providing information concerning the proposed repeal of the present Blood Test Act in Georgia. After discussion, it was duly moved and seconded that the Medical Association of Georgia request the Board of Health to furnish the Association with their recommendation on the alleged and proposed repeal of the Georgia Blood Test Law.

HEALTH INDIGENT CARE LAW

The Association Hospital Committee meeting January 10, 1960 recommended that the Medical Association of Georgia renew its support of the Health Indigent Care Law and further

that the Association send a letter to Governor Ernest Vandiver urging his consideration of making funds available to implement this law. The motion further requested that the Association urge the Governor's Commission on Aging to give full consideration to the implementation of this law in their recommendations to Governor Ernest Vandiver.

HEADQUARTERS OFFICE BUILDING REPORT

Secretary Chris J. McLoughlin, Chairman of the Association Headquarters Office Building Committee, reported on the purchase of this building. He outlined certain structural changes necessary in the building for its occupancy by the MAG Headquarters Office Staff to function in the new quarters. Members of the Executive Committee went over this data in detail and again inspected the new Headquarters Office building. The Executive Committee of Council then advised with Chairman McLoughlin as to the expenditures necessary for the operation of the Headquarters Office in the new Headquarters building.

There being no further business the meeting of Executive Committee of Council was adjourned at 4:15 P.M.

A.M.A. INITIATES ACTION ON MEDICAL SCHOLARSHIPS

THE AMERICAN MEDICAL ASSOCIATION initiated action this month on the establishment of a scholarship program for medical students with the appointment of a special study committee.

William F. Norwood, Ph.D., chairman of the division of legal and cultural medicine, College of Medical Evangelists, Los Angeles, was named staff director of the committee.

Dr. Norwood has been associated with the College of Medical Evangelists School of Medicine since 1933. From 1950 to 1951 he took a leave of absence to serve as a staff associate in a survey of medical education sponsored by the A.M.A. and the Association of American Medical Colleges.

The House of Delegates, policy-making body of the A.M.A., in December adopted a resolution that a scholarship fund should be established to aid deserving students to enter the field of medicine and that such a fund be backed by the A.M.A. as a primary sponsor. It acted on the recommendation of the A.M.A. Council on Medical Education and Hospitals which reported it had found sufficient evidence of a real need for a scholarship program.

"Most educators and college counseling offices believe that a significant number of well-qualified men and women are being deterred from entering medicine as a career because of financial considerations," Walter S. Wiggins, M.D., Chicago, secretary of the council, said, adding: "Superior students are being attracted into more lucrative and easily attained careers.

"The tasks assigned to this committee are of signal importance because it is urgent for medicine to develop and implement a program which will provide adequately for the future medical needs of our nation."

Dr. Wiggins said the committee also will seek ways to solve the over-all problem of increasing medical education facilities to keep pace with the nation's ever-expanding population and the growing demand for medical service.

Specifically, the committee was empowered to:
(1) Present a scholarship program, its development, administration, and the role of the American Medical

Association in fulfilling it.

(2) Ascertain the maximum to which medical schools could expand their student bodies while maintaining the quality of medical education.

(3) Ascertain what universities can support new medical schools with qualified students and sufficient clinical material for teaching—either on a two-year or a full four-year basis.

(4) Investigate the securing of competent medical faculties.

(5) Investigate financing of expansion and establishment of medical schools.

(6) Investigate financing of medical education as to the most economical methods of obtaining high quality medical training.

(7) Develop methods of getting well-qualified students to undertake the study of medicine.

(8) Investigate the possibility of relaxing rigid geographic restrictions on the admission of students to medical schools.

Dr. L. S. McKittrick, Brookline, Mass., who is chairman of the council, will serve as chairman of the committee. Other council members of the committee are Drs. W. Clarke Wescoe, dean of the University of Kansas School of Medicine, and John Z. Bowers, dean of the University of Wisconsin Medical School.

Three members of the House of Delegates named to the group are Drs. Willard A. Wright, Williston, N. D.; Charles G. Hayden, Boston, Mass., and Charles L. Hudson, Cleveland, Ohio.

Drs. James Z. Appel, Lancaster, Pa.; Julian P. Price, Florence, S. C., and Hugh H. Hussey, Jr., dean of the Georgetown University School of Medicine, Washington, D. C., all members of the Board of Trustees, also were named to the committee along with two other medical educators, Drs. John Mitchell, dean of the University of Pennsylvania School of Medicine, Philadelphia, and William R. Willard, dean of the University of Kentucky School of Medicine, Lexington.

A twelfth member of the committee remains to be appointed. The group will make its first report at the annual meeting of the A.M.A. in Miami next June.

"Eh? Oh, I never go!"

says Dr. J.M. Smart, H.&B.D.*

*(Horse and Buggy Doctor)



Don't Be A H. & B. D.

(Horse and Buggy Doctor)

Attend the Annual Session of

The Medical Association of Georgia

May 1-4, Columbus, Georgia

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COVER

Artist's conception of the new Headquarters Office Building of the Medical Association of Georgia by Joseph Dye.

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THE ALLERGIC CHILD - A PHILOSOPHY OF MANAGEMENT

There is possibly no area of medicine other than clinical allergy where there is so much understanding of the fundamental processes which are presumed to lie at the base of clinical phenomena with as little understanding of how these processes are related to the actual emergence of symptoms in an affected individual.

Victor C. Vaughan, III, M.D., *Augusta*

AGREEMENT IS UNIVERSAL that allergic manifestations are related to disturbances in the mechanism for immunity, and the variety of such disturbances which have been studied both in patients and in the laboratory is large and rapidly increasing; on the other hand, there is no exact laboratory model for clinical allergy in man, so that conclusions drawn from laboratory studies regarding the nature of allergic man are inferential and may be misleading. Moreover, studies of the individual fail to reveal why he is basically allergic or why his difficulties take the form unique for him. Under these circumstances, attempts to explain the allergic state range from a hypothetical genetic defect in molecular chemistry to the point of view that allergic difficulties grow more or less purely out of emotional states of early infancy and childhood. The truth lies between these poles and must be broadly enough conceived to encompass both.

Fortunately, our uncertainties regarding the allergic

state, real as they are, do not necessarily hinder us from helping our allergic patients, since there is a large body of clinical data which tells us empirically how this is to be done. These data lead to a conception of the problem faced by the allergic child which I believe to be well supported by clinical observation, and without which conception our study of the needs of the allergic child is likely to be incomplete and our therapy without maximal benefit.

The conception of the allergic state which I have found most helpful in instruction both of patients and of students, is illustrated by a few simple diagrams; these are purely descriptive, and, like the attempts of the ancients to describe the heavens, have an "as if" aspect which may depart far from the true facts. I believe, nonetheless, that if we handle our allergic child patient *as if* our conceptualization of his problem were accurate, we can help him.

These diagrams have the advantage over certain other ways of depicting the allergic state that they introduce a time scale, and do not depend simply upon a hypothetical "equilibrium" which might be

From the Department of Pediatrics, Medical College of Georgia, Augusta, Georgia.
Presented at the Annual Session of the Medical Association of Georgia, May 19, 1959, Augusta, Georgia.

construed as more or less static. I have found it useful while talking with patients to reproduce these diagrams on slips of paper, such as prescription forms, which the patient may take home for contemplation.

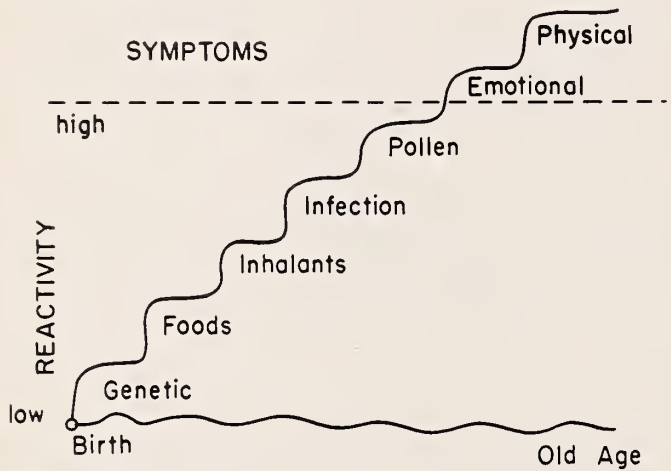


Figure 1.

Figure 1 introduces the concept. The horizontal solid line conveys the passage of time, from birth to old age. The vertical dimension represents the tendency of an individual to react in an allergic manner, and indicates that reactivity increases from some low level to a relatively high level before a threshold is reached (indicated by the dotted line) where allergic symptoms appear. It seems reasonable to expect that most people may have some tendency to react in the direction of allergic symptoms (here conveyed by irregularity in the base line for time) which is manifest at times of illness in the form of bronchospasm, cough, nasal discharge or edema, and the like, but that these reactive tendencies do not generally in normal persons reach the threshold for recognition as clinical allergy. In such normal persons it is possible to produce allergic symptoms through the use of drugs, but this is scarcely ever done.

A hypothetical allergic individual, whose reactivity is indicated by the rising step-like line in Figure 1, is born with the capacity to react in a manner which, if augmented, will lead to allergic symptoms. This capacity to react has been designated the *genetic* contribution to allergic symptoms. In early infancy the allergic individual has the opportunity to and may respond to foods with an increasingly reactive tendency, to which later may be added reactivity to such perennial inhalants as house dust, feathers, and wool, to infection, and still later to seasonal factors such as pollen and molds. Emotional tension may further add to the reactive tendency, and in some individuals may predominate among the factors

which contribute to the actual appearance of symptoms. Physical agents, such as heat or cold or the inhalation of non-allergic dust may also excite reactivity leading to symptoms. There are, then, at least these seven possible categories in which factors may exist which contribute to allergic reactivity, and there is good reason to believe that, as indicated, the effect of multiple excitants of the allergic state may be additive. It is unlikely, on the other hand, that allergic symptoms are ever generated by such a neat step-wise additive effect of equal parts of all seven factors as is suggested in Figure 1. Figure 1 suggests that a genetically disposed person, carrying a heavy load of allergenic foods, inhalants, infection, and pollen was pushed into symptoms by a relatively small emotional factor to which physical factors were later added. It would be most difficult to recognize such a person, if such existed, and it would be next to impossible to *quantitate* the individual contributions of genetic, food, inhalant, infectious, or pollen factors, especially with respect to levels of reactivity which existed *below* the threshold for symptoms. What exists below this threshold, like the underwater shape of an iceberg, we can only guess at.

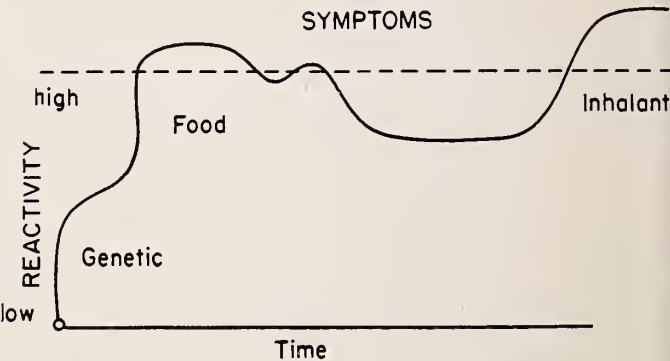


Figure 2.

Figure 2, on the other hand, might reasonably describe the allergic state of a child born with a fairly heavy genetic tendency to allergic reactivity who developed an increasingly active response to foods, eventuating ultimately in the production of a clinical symptom such as eczema in early infancy. With treatment, avoidance, or the passage of time the reactivity abates, only to reappear in later life as an asthmatic response to inhalant factors, at this time possibly supported by unchanged basic genetic tendency and by continuing food reactivity.

Figure 3 presents a somewhat more complicated scheme. Here a child with the capacity to react in an allergic manner is carrying a moderately heavy load of food and of house dust reactivity which is not enough to eventuate in allergic symptoms until infections occur; these may be otherwise undifferentiated respiratory infections, which precipitate asthma or asthmatic bronchitis. In such children it

is probably not allergic reactivity to bacteria which makes the child wheeze with infection, but the fact that he is carrying his genetic disposition concurrently with a fairly heavy load of house dust and food reactivity. Under these circumstances, modification of the diet and environment to minimize exposure to allergens sometimes with desensitization to house dust, will often result in such a lowering of the general level of reactivity that infections will not produce the allergic symptoms they have readily excited in the past.

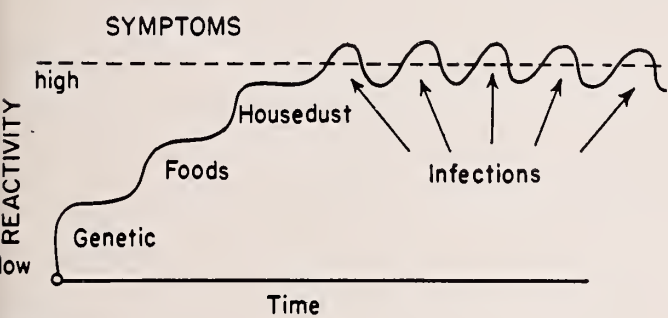


Figure 3.

The notion implicit in Figures 1, 2, and 3 that allergic symptoms may depend upon concurrent exposure to two or more excitants is by no means new. More than 30 years ago Warren Vaughan¹ called attention to clinical observations permitting no other interpretation of the relationship between allergen and symptoms, and many others have added to the body of clinical data which give support to this concept. It is not easy to find clear-cut clinical examples of this, but given the extraordinary complexities of the allergic state, this is scarcely surprising. What these observations really mean for us is that we cannot be satisfied that we have adequately determined the factors causing the emergence of allergic symptoms in a child until our study and management have brought maximal relief of symptoms. So long as major symptoms persist, we must continuously pursue the identification of the factors contributing to reactivity below the threshold level, exploring systematically each of the areas in which contributory factors may lie.

A final diagram belongs in this conception of the allergic child, and this diagram is given in Figure 4. There is a good deal of evidence to suggest that a heavy allergic load be tolerated only for a somewhat limited period of time without producing difficulties in the allergic individual struggling under this load. It is a common observation, moreover, that once the threshold for symptoms is exceeded, it may be quite difficult for the allergic individual to restore himself immediately to a point where symptoms are once again as satisfactorily under control as they were

before the threshold was exceeded. An important complementary consideration is that if an individual reactive to a given allergen is able to avoid it for a sustained period of time, limited tolerance to it may appear which did not exist before. Clinical control of allergic disorders ought then, ideally, to consist not only of those measures which abolish symptoms, but also of reduction of the entire allergic load of the susceptible individual to the point where his tolerance, freedom of action, or "elbow room" is as great as possible. When this point is attained, we could recommend that the allergic load be kept minimized by whatever measures respecting home and diet can be instituted and maintained without undue interference with normal social and cultural pursuits.

Lightening Allergic Load

That portion of the lightening of the allergic load which carries the attempt at clinical control beyond the simple relief of symptoms has been designated prophylaxis in Figure 4. Glaser² and others have drawn attention to the probable usefulness for many potentially allergic children of bringing prophylactic measures into play even before they have their first symptoms. I will not review the evidence which Glaser gives that in families where milk allergy in infancy has been conspicuous, the likelihood of allergic difficulties in a new infant can be materially lessened by the feeding of this infant on a soy bean substitute for cow's milk. I believe that for some infants this makes the best possible sense, and that in rare infants such prophylaxis might even extend to the ingestion of cow's milk by the mother during pregnancy. The concept of prophylaxis in this sense can be carried further; it is entirely reasonable to suggest that the family of the potentially allergic child attempt generally to create an environment where he will be to the least degree possible systematically

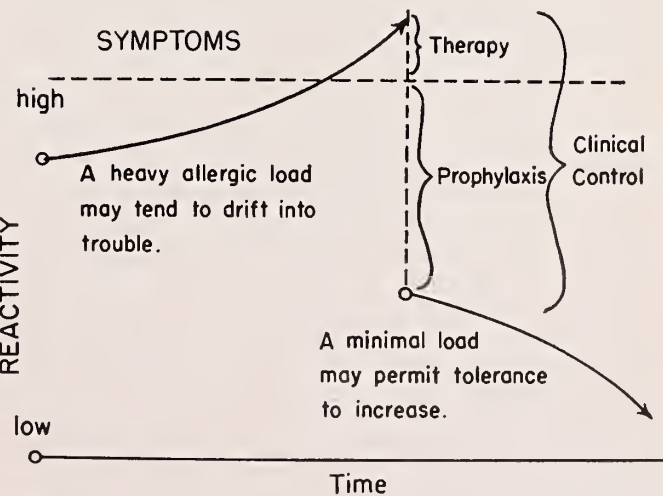


Figure 4.

exposed to substances of high sensitizing potential. These substances include house dust, feathers, wool, and other animal products and danders; they include cow's milk, egg, wheat, citrus fruits, chocolate, tomato, various nuts, the pea and bean group generally, strawberries, and seafoods. Except for wheat and cow's milk, diets free, except for occasional contact of most of these substances are relatively easy to arrange, and with adequately close scrutiny, can be so constructed that all necessary food factors are being supplied in sufficient quantity. Fur bearing and feathered pets ought not generally be allowed in the same household with allergic children.

These prophylactic measures, it is worth emphasizing, can usually be instituted in most allergic families without great difficulty. Even where a sub-optimal heating plant makes general house dust control difficult during the winter season, a room for sleeping can generally be found in the house in which the allergic child can be kept relatively free of exposure to dust during the sleeping hours, his longest stay in any one place.

Evaluation of Considerations

The considerations embodied in Figures 1 to 4, as interpreted above, can be recapitulated in the following terms: (1) the allergic child is endowed by his genetic nature with a pervasive tendency to react with allergic symptoms to a variety of situations among which we may distinguish (a) repeated exposures to foods or inhalants or contactants which have the potentiality of sensitizing him, (b) infection, (c) situations involving acute or chronic emotional tension, and (d) certain sensory stimuli such as heat, cold, non-allergenic dust, and the like; (2) the allergic child may react to *combinations* of allergens or excitants which may not singly cause difficulty (infection acts sometimes primarily, but more often when coincident exposure to allergens cannot be controlled); (3) the management of the allergic child should comprise not only a careful search for specific allergens, but should also include minimizing of contact with substances of high sensitizing potential regardless of whether clinical reactivity is evident at any given moment, and adequate management should include realistic appraisal of emotional factors, not only from diagnostic and therapeutic standpoints but prophylactically as well. In this last respect it is to be hoped that a realistic acceptance of the nuisance of allergic difficulties can be created in the parents of the allergic child without either over-optimism or undue pessimism as to the future (either of which may be iatrogenic). Allergic chil-

dren *cannot* be expected to "outgrow" their allergic reactivity, though as many as 50 per cent may enter periods of their lives when they are symptom-free, without restrictions. It is to be hoped and expected that the best possible allergic management during a symptomatic period will offer the child the best chance to enter a symptom-free period without residual structural, functional, or emotional damage. It is worth emphasizing that of the major chronic diseases of children, the allergic states have about as good a prognosis as any; while every reasonable thing that *can* be done for the adequate suppression of the child's allergic reactive tendency *ought to be* done, the restrictions of his freedom of activity should not be more rigid than necessary to achieve this end.

Neither the clinical aspects of allergic disease in children nor the manner in which diagnostic measures such as skin tests may be used in the study of these children nor the specific measures of desensitization are germane to this philosophical discussion of the problem of the allergic child, important as they may be in pointing the way to reducing the reactivity of the child from the level at which symptoms occur to the level at which his allergic load is minimized. But the manner in which diagnostic measures are chosen and interpreted, and the planning of desensitization and other therapy should rest in a major way upon the conception here developed of the dynamics of the problem of the allergic child.

Summary

The problem presented by the allergic child has been graphically presented in diagrams found useful in orienting patients to the nature of their problem. These diagrams highlight: (a) the concept that the basic problem of allergic people is a tendency to react with allergic symptoms under a complex set of exciting stimuli, (b) the concept that this tendency to react may be at a relatively high or low level when the patient is currently without symptoms, and (c) the concept that the patient is best managed not only when his symptoms are controlled but when his tendency to respond to life situations with an increase in allergic reactivity is brought to the lowest possible ebb. The meeting of this last requirement calls for prophylactic measures which may reach well beyond symptomatic therapy.

Medical College of Georgia

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TEFLON GRAFTS IN THE DIRECT SURGERY OF ARTERIOSCLEROSIS

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*Experimental studies indicate that the long term results with teflon grafts
should be better than with other grafting materials available.*

ALTHOUGH ARTERIOSCLEROSIS is a generalized disease, it has been found that in many instances it is, at least symptomatically, localized in one segment, the remainder being relatively free of disease. Paralleling the importance of this knowledge has in the past ten years been the development of satisfactory vascular substitutes. Oudot in 1950 resected an occluded aorta and a year later Leriche an aneurysm and replaced them with homografts. Since that time there has been a marked expansion of the field of vascular surgery to the point that lesions from the the aortic arch to the popliteal arteries can now be successfully resected and replaced by a graft.

Homografts played an important role in the expansion of the field of vascular surgery. The limited supply, inconvenience in procuring, storage, and recent evidence that there is some degeneration after long periods of implantation, however, made them less than ideal and led to the search for a satisfactory synthetic substitute.

Teflon is chemically the most inert plastic known, is practically non-wettable and incites minimal tissue reaction in the body. The results in our laboratory in a comparative study of grafts of nylon, dacron, orlon, ivalon sponge, and teflon, under varying circumstances in some 600 dogs during the past four years, have indicated that teflon is the better material. Grafts of teflon gave the only satisfactory results when vessels less than 9 mm. in diameter were replaced. The short term results were equally good with all materials when larger vessels were

replaced, but complications consisting of rupture or delayed bleeding occurred in all except the teflon grafts by three to four years.^{3,4}

Due to mechanical difficulties in its handling, it was not until two years ago that teflon became available in a form that was considered suitable for human usage. This report is based upon the experiences with grafts of this material in 76 patients with arteriosclerosis.

The disease manifests itself clinically by the production of aneurysms and/or occlusion. They are such different problems that they will be discussed separately.

Aneurysms

Aneurysms due to arteriosclerosis are most commonly fusiform or saccular and may involve any portion of the aorta or peripheral vessels. The most common area of involvement is the abdominal aorta where 95 per cent of them arise below the level of the renal arteries. Weakness due to disease in the walls of the vessels leads to ballooning or an increase in diameter. This results in an increased lateral pressure on the walls in the ballooned area. The increased lateral pressure on a weakened area produces further dilatation and a vicious cycle is established. Rupture is the eventual outcome if the patient does not die of other causes.

In follow-up studies by Estes, Wright, and others on patients with untreated abdominal aneurysms, it was found that 45 per cent were dead by one, 67 per cent by three, and 80 per cent by five years.^{2,9} Less than five per cent of the patients were alive after eight years and none survived as long as ten years. Sixty-three per cent of the deaths in Estes' series were due to rupture of the aneurysms. The normal

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life expectancy of a person of similar age is 80 per cent for five years and 65 per cent for eight years.

In this series 21 aneurysms were operated upon in 20 patients as elective procedures. Eighteen involved the abdominal aorta, one the popliteal, and another the femoral and popliteal arteries of the same leg. All were resected and replaced by teflon grafts. The procedures were successful in all except one patient who died of hypotension of undertermined etiology on the third postoperative day. The mortality rate was five per cent.

Nine patients were seen after evidence of rupture had occurred. Four of these died before surgery could be done. One died of shock during the operative procedure and another in the immediate postoperative period from myocardial infarction precipitated by hypotension. Another died indirectly from leakage of the graft. Two of the nine or 22 per cent of the patients seen after evidence of rupture had occurred were salvaged by surgery.

The results in these and similar patients reported by others emphasize the importance of diagnosing and treating aneurysms before evidence of rupture has occurred. Patients with extensive disease tolerate resection surprisingly well if they can be gotten into optimum condition preoperatively and hypotension prevented during surgery. Neither of these may be possible after evidence of rupture has occurred.

The operative technique employed consisted essentially of isolating the aneurysms, proximally and distally, removing them between occluding clamps, and bridging the defects with suitable grafts (Figure 1). The proximal and distal vessels should be occluded prior to any significant manipulation of the aneurysm. This will shorten the operative procedure and prevent the dislodgment of emboli from the laminated thrombi in the walls of the aneurysm. The operative technique is otherwise similar to that employed for obliterative disease.

Obliterative Disease

Though obliterative disease due to arteriosclerosis may be extremely variable in its clinical and pathologic features, it tends to assume recognizable clinical patterns particularly in terms of location and extent of occlusion. The differences in the patterns of the disease as well as the results with treatment are such that they are best divided according to the level of the major occlusion. These include aortic-iliac and femoral-popliteal.

Aortic-Iliac Occlusion

Twenty-nine patients with aortic-iliac occlusion were operated upon. The complaints in most of these was intermittent claudication of the gluteal region,



Figure 1: (A) Aneurysm of abdominal aorta. Note good aorta below the renal arteries above and iliac arteries below. It was resected and replaced by woven teflon graft (B).

thighs, and calves of the leg. Pain at rest and trophic changes, though usually minimal, were present in some. Two patients had pregangrenous changes of the toes and feet. The occlusion in these was partial or complete involving in variable degrees regions from the abdominal aorta at the level of the renal arteries distally to the femoral arteries. In three patients there was also occlusion of the femoral arteries, but with good popliteals that made them amenable to by-pass grafting. Eighty per cent of the patients with claudication and 60 per cent of those with clinical evidence of more advanced ischemia were candidates for direct surgery.

The vascular channel was restored by excision and grafting or by-pass grafting. The indications for each were dependent upon the location and extent of the blockage. In the presence of destructive disease in the region of the bifurcation, particularly when the occlusive process was well localized, the diseased segment was removed. Aneurysms above the level of occlusion requiring resection were encountered in five cases.

By-pass procedures were employed in patients with long or recurrent segmental occlusions, and particularly those with partial occlusions and borderline outflow tracts (Figure 2). The advantages of this procedure are less operative trauma and minimal interruption of the main vascular channel as well as collateral vessels upon which the livelihood of the extremity will be dependent in the event of a graft failure.

Utilizing either resection or by-pass techniques, with or without aneurysms, the branches of the graft were sutured usually end-to-side to the first good vessel distal to the area of major occlusion. The common iliac arteries were employed when feasible so that circulation to the gluteal region through the internal iliacs could be restored. In others the grafts were sutured to the external iliacs or femorals.

By-pass grafts were placed from the aorta to the

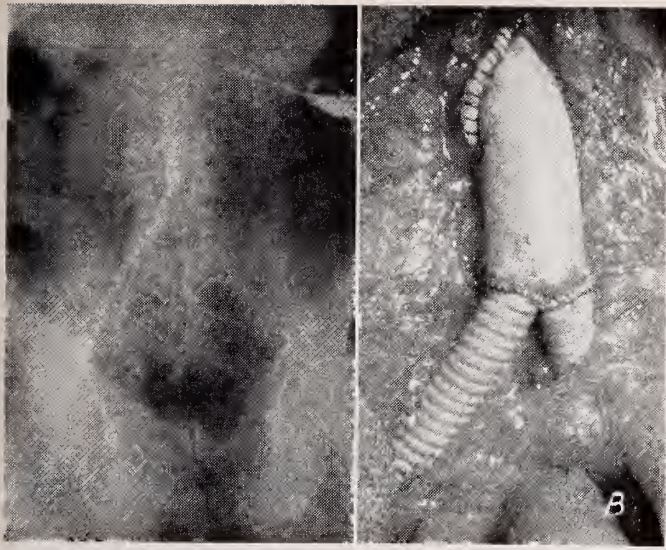


Figure 2: (A) Aortogram demonstrating occlusion of terminal aorta and iliac arteries. A by-pass teflon graft was placed end-to-side from the aorta to the iliac arteries (B). The graft in Figure 1 B was constructed by removing the iliac branches from a straight woven graft and replacing them with woven crimped tubes. This eliminates buckling at the crotch of the "Y" that is inherent in prefabricated grafts (see text).

popliteal arteries in three patients; bilateral in one. In these the circulation to the upper legs was restored through the deep femoral arteries by performing side-to-side anastomoses of the grafts to the common femorals.

Occlusive plaques were frequently encountered at the origins of the internal and external iliacs, deep and superficial femoral arteries, where the distal ends of the grafts were to be sutured. These were removed by endarterectomy prior to performing the anastomoses.

Bifurcation grafts of teflon are still in the developmental stages. In the first part of the series, prefabricated grafts were employed. In all the ones yet produced, there is buckling at the crotch of the "Y" after insertion. This has been eliminated by removing the branches of a woven bifurcation graft and replacing them with woven or knitted, crimped tubes (Figure 1B and 2B). This eliminates the buckle and allows a smoother flow which we have learned from our experimental studies is important in maintenance of patency of a graft. This type bifurcation graft was employed in most of the patients in this series. The manufacturers will eventually produce a suitable graft making this unnecessary.

Results

The overall results in patients with aortic-iliac occlusion were good with a relatively low morbidity and mortality rate. The patients were classified as successful only if their symptoms were relieved, pulses distal to the point of major block restored and maintained during the periods of observation. Aortograms were not done in patients who had good restoration of pulses because it was felt that the

information gained was not worth the risk involved.

Successful results were obtained in 27 of 29, or 92.9 per cent of the cases. This is better than the results obtained previously with homografts. They were employed, however, earlier when the procedure was in the developmental stages and less was known concerning techniques and the selection of patients. In vessels this size the method of approach or the grafting material, within reason, will make little difference in the short term results. This will be more apparent after longer periods of observation.

The failures were due to thrombosis of the grafts in patients who had extensive distal disease and inadequate outflow tracts. One of these had a good result on one side, while the other branch of the graft thrombosed. Though the patient was actually benefited by the procedure, it is placed in the failure group. By-pass grafts were successful in two of the patients in whom grafts were placed from the aorta to the popliteal arteries. In the other, the femoral portion of one limb of the graft thrombosed and the patient expired. The cause of death was not determined, but it is attributed at least partially to technical errors.

Femoral-Popliteal Occlusion

The presenting symptoms of the patients in this group were claudication, pain at rest - ranging from mild to severe, pregangrenous changes, ulceration, and frank gangrene. The occlusive process in many was well localized at various levels of the femoral and upper popliteal arteries, while in others was diffuse extending distally to the lower popliteals and tibials (Figure 3). Patients with extensive disease were more common than in the aortic-iliac group, and less of them were candidates for direct surgery. Only 50 per cent of the patients with good circulation at rest and less than 20 per cent of those with more advanced evidences of ischemia, by our present criteria, have good enough distal vessels to warrant direct surgery.

By-pass grafting technique was used for the reasons outlined. The grafts were placed from the com-

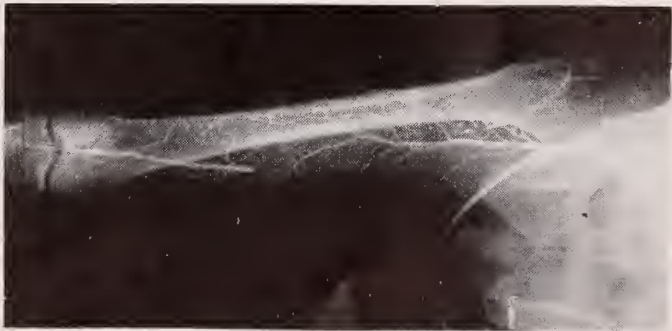


Figure 3: (A) Arteriogram in 50 year male with intermittent claudication in the calf of the leg. There is complete occlusion of the superficial femoral artery with good filling of the popliteal and tibial arteries below. A by-pass graft is inserted as outlined in Figure 4 with restoration of pedal pulses.

mon femorals above to the distal femoral or popliteal arteries below the areas of occlusion (Figure 4).

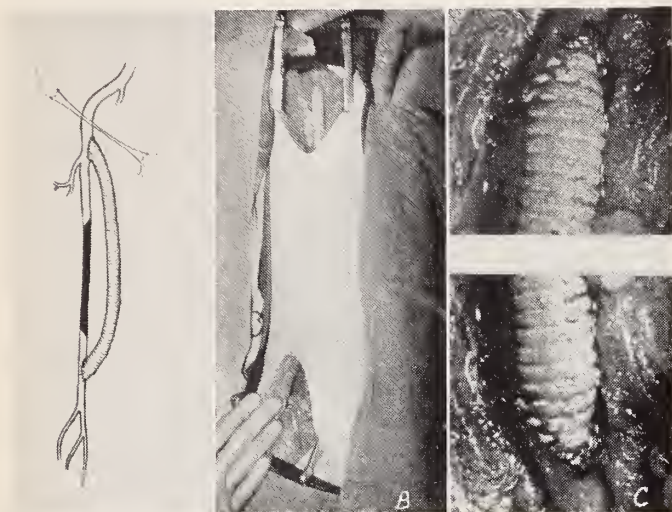


Figure 4: By-pass graft technique in patient with femoral artery occlusion—schematic drawing (A), overall (B), and close up (C) views. The graft is placed in a tunnel produced by blunt dissection between the incisions and sutured end-to-side to the common femoral artery above and the popliteal artery below the level of occlusion.

Grafts for by-passing disease in the iliac, femoral, and popliteal vessels are long, have small diameters, and cross flexion creases in the groin and knee. Maintenance of patency is the primary problem. Knitted, braided, and woven, purified teflon tubes, crimped to prevent buckling, have been evaluated in some 160 dogs. The best results were obtained with a recently developed, closely-knitted tube that seems to have about the desired porosity to maintain patency and allow healing, but at the same time not excessive to the point of allowing delayed bleeding. This was a problem with the braided and previously evaluated knitted tubes.

Woven and knitted tubes were utilized in the patients in this series with equal results. The experimental studies have shown, however, that the woven tubes available were not sufficiently porous and 20 - 30 per cent became occluded by thrombosis. The knitted tubes are therefore being used exclusively at the present time.

Success implying relief of ischemia and return of pedal pulses that were maintained during the period of observation was obtained in 12 of 19, or 63.2 per cent of the patients. There were no deaths and no extremities lost directly attributable to the procedures. In many of the patients classified as failures, the symptoms and signs of ischemia were actually improved and none were made worse.

Late failures due to thrombosis in two patients who originally had a good result were encountered

at six months to one year. The failures were due in one to progressive occlusion of the distal and another the proximal vessels. One of these subsequently had the graft replaced with a good result.

The results with grafting for femoral-popliteal occlusion were not as good as those with aortic-iliac occlusion. This is due primarily to the extent of the disease and size of the vessels replaced. In the early part of this series, many patients with borderline outflow tracts were operated upon. The percentage of failure in these was high and there were no long term successes in those in whom pedal pulses were not restored when the occluding clamps were released. During the past 12 months, using more rigid criteria for the selection of cases, our success rate has increased to 75 per cent. DeBakey, Linton, and Humphries have reported 85 to 90 per cent good results in replacing vessels this size.^{1,5,6} Others, like ourselves, have not been as successful, reporting good results in 50 to 70 per cent of their patients.^{7,8} It is hopeful, but doubtful, that this can be improved until further improvements in restorative techniques and grafting materials are available.

The place of direct surgery in the treatment of arteriosclerosis can only be told with longer follow-up, and will depend upon the rate of progression of the disease and the fate of the substitute employed. The early good results in our patients followed up to five years and of others for six to eight years have been well maintained and are encouraging particularly in the aortic-iliac group. Clinical studies with the synthetic materials are not of sufficient length to tell the fate of grafts. From its chemical properties and the results in experimental animals after four years, one can predict, however, that teflon will maintain its strength and function satisfactorily for a long period of time, and one's worry should be more with the remaining vessels than with the prosthesis.

One must remember the nature of the disease itself in considering any surgical approach, and realize the limitations. They are in most instances or until someone finds a method of preventing progression of the disease palliative procedures aimed at restoring or improving the circulation to only one portion of the body. There is, for instance, little to be gained in restoring circulation to a leg when there is none to the heart or brain. Our experience to date is sufficient, however, to maintain an optimistic view and predict a further expansion of the direct approach to obliterative disease of all of the major vessels including the coronaries, carotids, and renals.

Summary

Teflon grafts suitable for human usage became available during the past two years and have been

employed in 76 patients with obliterative disease or aneurysms.

Twenty-one aneurysms were resected in 20 patients as elective procedures with one death. Only two of nine, or 22 per cent of the patients seen after evidence of rupture had occurred, were salvaged. The importance of early diagnosis and treatment is stressed.

Twenty-nine patients with occlusive disease localized to the aortic-iliac region were grafted, with good results in 27, or 92.9 per cent.

By-pass grafts of woven and knitted teflon were employed in 19 patients with occlusion of the femoral and upper popliteal arteries, successfully in 12, or 63.2 per cent. Recent improvements in grafting materials and selection of patients have increased this to 75 per cent. The lower success rate in these is attributed to the more extensive disease and small size of the arteries.

Addendum

Since submission of this paper thromboendarterectomy has been done in 19 patients with occlusion of the femoral and popliteal arteries with only two failures during the period of observation. The results in these patients are better than those with by-pass grafts for occlusion in the same area followed over a similar period. It is now considered the procedure of choice if technically feasible.

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1960 CALENDAR OF MEETINGS

State

- May 1-4—Annual Session, Medical Association of Georgia, Municipal Auditorium, Columbus.**
Oct. 12-13—Annual Meeting, Georgia Academy of General Practice, Dinkler Plaza, Atlanta.

Regional

- May 2-4—Louisiana State Medical Society, Capitol House, Baton Rouge, Louisiana.
May 7-11—North Carolina Medical Society, Hotel Sir Walter Raleigh, Raleigh, North Carolina.
May 10-12—Mississippi State Medical Association, Hotel Heidelberg, Jackson, Mississippi.
May 17-19—South Carolina Medical Association, Ocean Forest Hotel, Myrtle Beach, South Carolina.
Sept. 14-16—Southern Trudeau Society and Southern Tuberculosis Conference, Hotel Francis Marion, Charleston, South Carolina.
Oct. 31-Nov. 3—Southern Medical Association, St. Louis, Missouri.

National

- June 13-17—American Medical Association Annual Meeting, Miami Beach, Florida.**
May 5-8—Student American Medical Association, Statler-Hilton Hotel, Los Angeles, California.

- May 9-13—American Psychiatric Association, Inc., Hotel Traymore, Atlantic City, New Jersey.
May 15-20—National Tuberculosis Association, Statler and Biltmore Hotels, Los Angeles, California.
May 16-18—American Trudeau Society, Statler and Biltmore Hotels, Los Angeles, California.
May 30-June 1—American Gynecological Society, Williamsburg Inn, Williamsburg, Virginia.
June 5-28—Fifth Medical Seminar Cruise, Duke University School of Medicine, to the Baltic, leaving from Wilmington, N. C. June 5 or New York, June 8.
June 6-24—Forty-fifth Session of the Trudeau School of Tuberculosis and Other Pulmonary Diseases, Saranac Lake, New York.
June 8-12—American College of Chest Physicians, Miami Beach, Florida.
June 11-12—American Diabetes Association, Inc., Hotel Deauville, Miami Beach, Florida.
Aug. 27-Sept. 1—American Hospital Association, Civic Auditorium, San Francisco, California.
Sept. 1-6—Postgraduate Course in Pediatrics, The Stanley Hotel, Estes Park, Colorado.
Sept. 13-15—National Cancer Conference, American Cancer Society, Inc., and the National Cancer Institute, Minneapolis, Minnesota.

ALCOHOLICS: IDENTIFIED AND CLASSIFIED

This paper deals primarily with individuals whose alcoholism is associated with a personality disorder.

Thomas E. Fulghum, M.D., *Augusta*

WHEN THE WORD "alcoholic" is used, it refers to that type of individual who, due to his personality defect, has allowed himself to become mentally and physically dependent upon alcohol.

The following conclusions and classifications are based on first hand experience gained in the treatment of over 2,000 alcoholics under hospitalization.

From personal observation of these patients we feel qualified to make this statement: in addition to his ever-present, firmly imbedded psychological need for tension relief, the alcoholic also has an abnormal mental reaction after his system makes physical contact with alcohol.

This is indicated by the marked contrast in the behavior pattern of a normal drinker and an alcoholic when they are both at the same blood alcohol level. Whether this is due to deep-seated psychological defects, or to metabolic disorders is as yet undetermined.

I believe, as is suggested by Noyes and Kolb in *Modern Clinical Psychiatry*, that the drive of the underlying personality disorder is so strong that a normal inhibition-release blood alcohol level is all that is necessary to permit an alcoholic to swing into his usual uncontrolled behavior pattern.

Some exert more control than others as is shown by the increased time element spent in each downward phase. This variation in control is dependent upon two factors; i.e., the depth of the individual's psychic need, and his emotional environment.

Dr. Robert V. Seliger of the Neuropsychiatric Institute, Baltimore, has summarized individual motivations for excessive drinking as follows:

- "1. A self-pampering tendency, which reveals itself in a refusal to tolerate, even briefly,

boredom, sorrow, anger, disappointment, worry, depression, and feelings of inferiority and inadequacy.

2. An instinctive urge for self-expression without the determination or staying power to organize this urge into creative productivity.
3. A more than usual craving for emotional experiences which call for the removal of intellectual restraint.
4. Powerful hidden ambitions without the necessary resolve to take practical steps to attain them.
5. A tendency to flinch from the worries and responsibilities of life and to seek escape from reality by the easiest available means." (M. Clark, *Medicine on the March*, pg. 201)*

The patients that we have treated in the hospital have shown more tendencies by far toward one and three as motivating factors in their excessive drinking.

Occasionally, while in the stage of acute alcoholism a frank psychopath is admitted for hospitalization. In the writer's opinion, Dr. H. M. Cleckley sets forth the most valuable differentiating points between an alcoholic and a psychopath. He indicates that an alcoholic still possesses the important components of his personality structure, and even though his driving forces are defective they are still identifiable as deviated normal human traits. And most important of all, he points out that the alcoholic is capable of insight and can want to get well.

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The psychopathologic process in an alcoholic is active, and under the proper therapy is reversible.

Dr. Cleckley states that in the psychopath the above factors are usually absent. In discussing the differences between an alcoholic and a psychopath he refers to a similar contrast between a hysteric and a schizophrenic.

In addition it is generally accepted as the above writer says, that alcohol does not bring something out in a person that is not already there.

In order to simplify the identity and diagnosis of alcoholics, we wish to present the following classification consisting of the four phases in which an alcoholic dwells on his way down. Each phase is given with its identifying characteristics listed beneath it.

The Fringe Alcoholic

Identified by:

- 1. Undue relief from tension with alcohol.
- 2. Progressive abnormal loss of good judgement with each drink.
- 3. A desire to take more drinks more often than a normal drinker.

The Marked Alcoholic

Identified by:

- 1. Blackouts.
- 2. Private drinking.
- 3. Frequent thinking about alcohol, and the relief he gets from it.
- 4. Remorse—moderately.

The Severe Alcoholic

Identified by:

- 1. Frequent morning drinks.
- 2. With every first drink he ends up drunk.
- 3. Alibis, remorse, and resentment—severe.
- 4. Neglects food while hoarding and hiding his alcohol.

5. Between drinks he is restless, anxious, and suffers from insomnia.

The Absolute Alcoholic

Identified by:

- 1. Believes he has to have alcohol to keep going.
- 2. No longer tries to put up a front to his family, doctor, or other friends.
- 3. Every waking thought when without it, is occupied with how to get alcohol.
- 4. Is now obviously damaged mentally, physically and spiritually.

The alcoholic usually goes into the first phase with his first contact with alcohol. However, sometimes his tendencies are so latent that he appears to drink normally for years.

At the present time, most patients are in the severe or absolute phases before hospitalization. Since it usually takes from 15 to 18 years to go from the fringe phase to the absolute phase, a great deal of physical and mental damage could be prevented by a patient-convincing diagnosis made in the earlier phases. This is possible by recognizing the identifying characteristics of these early phases.

The possibility for this type of preventive medicine occurs mostly in the field of the general practitioner who will find a very useful and helpful ally in Alcoholics Anonymous.

It is estimated that 250,000 alcoholics have recovered through the group therapy program offered by this fellowship.

On the basis of this record, it is our policy to introduce patients to Alcoholics Anonymous; and on dismissal from the hospital to refer them to this group with the approval of their family doctor.

2036 Virginia Avenue

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A. H. A. ANNUAL MEETING

THE AMERICAN HEART ASSOCIATION'S 1960 annual meeting and scientific sessions will be held in St. Louis, Oct. 21-25. The 33rd scientific sessions are scheduled Oct. 21-23 in Kiel Auditorium.

June 1 has been set as the deadline for submission of abstracts of papers to be presented at the scientific sessions and for space applications for scientific exhibits. Papers intended for presentation must be based on

original investigations in, or related to, the cardiovascular field.

Official forms for submitting abstracts and applications for scientific exhibit space may be obtained from D. F. J. Lewy, assistant medical director of the American Heart Association. Space for industrial exhibits may be requested through Steven K. Herlitz, Inc., 280 Madison Ave., New York 16, N. Y.

MECHANICS IN MEDICINE

Henry R. Perkins, M.D., *Augusta*

Many upper respiratory problems may be relieved by mechanical correction of defects if such are recognized.

WHILE ORTHOPEDISTS AND other surgeons are expected to be passably good mechanics; all physicians regardless of field of practice or specialty should be mechanical minded. As a point of illustration one may see recurring sinus or middle ear infections as a problem in mechanics. Today the otolaryngologist recognizes the necessity of basing treatment of general diseases of the upper respiratory system on the principal of establishing and maintaining adequate aeration and drainage with the least possible disturbance of physiological function. Special infections, allergies, and malignancies may also require certain additions.

The practitioner should always be conscious of the special mechanics of the area involved. He should recognize those contributing factors which do not respond to the "wonder drugs." These "wonder drugs" are valuable treatment aides but they have done much to blind the profession to the importance of the faulty mechanics behind the recurrent, the incompletely resolved, and the chronic conditions that are so largely preventable. The faulty mechanics frequently can be corrected before the damage is irreversible.

With normal construction and relationships the vestibule of the nostril has the smallest cross sectional area of any point in the nose and nasopharynx. Because of this relationship the relative vacuum produced by increasing the thoracic volume on inspiration is reproduced throughout the upper respiratory system. The air contained in the paranasal air spaces partially empties into the nose and conversely the

relative high pressure of expiration results in an inspiratory phase for the accessory air spaces or sinuses—of which the middle ear is a part. Adequate cross sectional area may be decreased because of deformity, overgrowth, or swelling of a normal, or of abnormal tissue of the encompassing walls. When the cross-sectional area of some point in the nose or nasopharynx become less than that of the vestibule the reverse phase respiration of any accessory air spaces whose ostia lie between the obstruction and the vestibule then ceases or diminishes. The mechanical fault must then be relieved before the normal function can be re-established.

The value of the lymphoid tissue in the mucosa of the pharynx and nasopharynx in the production of useful and desirable antibodies in the young child is accepted as considerable. The indiscriminate removal of this tissue before this function has been accomplished is indefensible.

Recurring Upper Respiratory Disease

When faced with the problem of recurring prolonged upper respiratory disease especially when such infections involve the middle ear and when these infections refuse to respond completely to medical care because of a mass of hypertrophied or chronically swollen lymphoid tissue disturbing the mechanics of the upper respiratory system, then the failure to remove the offending excess tissue becomes just as indefensible. In the middle ear as in other paranasal sinuses, the respiratory mucosa lies directly on bone or cartilage; its stroma is loose, vascular,

and highly resistant to inflammatory diseases, and will recover completely when the infection is controlled. Repeated prolonged, or overwhelming infections may destroy this resistant mucosa. If healing takes place following such destruction the resulting stroma is much more dense, less vascular, and greatly less resistant to infections. The middle ear or sinus then becomes either chronically infected or potentially so, and this condition is usually permanent. A chronic middle ear problem occurs when permanent irreversible degenerative tissue changes have occurred, and the area is, either actually or potentially, permanently infected. The optimum time to successfully treat an ear infection is before the irreversible tissue changes occur.

Any physician who has followed cases of adenoidectomy in young children, performed for the above mentioned reasons, has seen regeneration of the nasopharyngeal lymphoid tissue—frequently to the extent of requiring repetition of the procedure within a relatively few months. He has also seen failure to repeat result in the opinion that the procedure had failed, despite the evidence of improved upper respiratory function during the time of effectiveness.

In the adult a completely normal septum is a rarity. It is surprising how much septal deformity is compatible with good function, and conversely how a little deformity can be responsible for so much disturbance. The deciding factor is where the deformity of the septum occurs, whether the deformity results in a cross sectional area less than the narrowest point forward and whether that narrowest point is central to the ostia of the anterior group of paranasal sinuses—under the anterior end of the middle turbinate. Correction of offending septal deformities is a conservative procedure in that it improves function by restoring normal physiology. The removal of polyps that have passed the stage of reversibility, and of other non-malignant tumors, at a reasonably early stage simplifies the procedure, and usually facilitates the medical handling of the situation.

Summary

The application of mechanical correction to faults that produce disturbances of physiology and result in disease is a responsibility of every physician treating upper respiratory problems.

1110 Southern Finance Building

A. M. A. EMBARKS ON MAJOR STUDY OF MEDICAL CARE COSTS

A "COMMISSION ON THE Cost of Medical Care," to delve into every phase of medicine where cost or spending is involved, was announced by the American Medical Association recently. An initial grant of \$100,000 was appropriated to launch the study.

"This study-project is being undertaken," said Dr. Louis M. Orr, Orlando, Fla., president of the A.M.A., "because the American public is spending increasing amounts of money for all types of medical care. These expenditures involve the peoples' lives, health, and pocketbooks. We would like to find where economies may be achieved in the best interest of the patient. The commission will analyze the cost picture from every angle and try to come up with some sound advice and suggestions."

The commission, whose members will be announced shortly, will serve as a "little Hoover Commission" to study all medical care costs, including doctors' fees, hospital charges, nursing cost, drug expenditures, and health insurance premiums.

Dr. Orr said that American medicine is "tackling the

cost problem in order to help people better meet their obligations when illness strikes, and to help clarify the confusion that exists relative to such cost."

The American Medical Association, Dr. Orr said, is "well aware that more physician-patient relationships have been strained by a misunderstanding about fees than perhaps any other disagreement. Is such misunderstanding due to lack of frank discussion between doctor and patient, or is there some other reason? A patient has every right to know why he needs treatment or surgery, what it will consist of, and what it will cost—particularly where major services are rendered."

It is hoped, Dr. Orr added, that the study will also provide some sound advice for the consumer on how to get the most benefit from his health dollar.

In conducting this study, the A.M.A. commission will consult economists, health insurers, prepayment plans, hospital representatives, a cross section of patients, and others whose knowledge and opinions will be helpful.

Members of the commission will be announced shortly, and it is expected to be functioning this spring.

DIFFERENTIAL DIAGNOSIS IN RECTAL BLEEDING

Malignancy should always be suspected, especially in adults.

Robert L. Robinson, M.D., *Atlanta*

RECTAL BLEEDING CAN BE and is dangerous. Lack of interest and procrastination of the patient and doctor can lead to regrettable results. In pediatrics rectal bleeding is not an uncommon finding but is one which often is the cause of real anxiety to the parents and physician. In children most rectal bleeding comes from local transient lesions, and in many instances is small in quantity, and ceases spontaneously. Severe rectal bleeding frequently indicates a surgical lesion. Milder bleeding is usually associated with lesions that can be treated conservatively. The presence or absence of diarrhea is of diagnostic value, while tarry stools frequently indicate systemic diseases requiring prolonged management.¹ Therefore, it is the physician's obligation to differentiate between the serious and the inconsequential. To help accomplish this it will be well to consider the various etiologic lesions responsible for rectal bleeding and suggest methods of study to determine the etiology of bleeding in a given case.

Blood may be found in the stool in two forms:

1. *Unaltered:*

The red blood cell morphology is unchanged, and if in sufficient quantity may be recognized grossly. If only a small amount is present microscopic examination will be necessary to demonstrate the blood.

2. *Altered:*

When the blood has been present in the gastrointestinal tract for a longer period of time, it will have become decomposed, and is referred to as melena. In the newborn as little as 2.6 cc. of swallowed blood may produce melena or tarry stools in seven to 17 hours. In the adult usually 50 to 100 cc. of blood in the GI tract is required to cause melena. To demonstrate blood in smaller amounts we must

rely on clinical tests and microscopic examinations.

Before any evaluation of the rectal bleeding can be made it is essential that these questions be answered:

1. Quantity of blood passed?
2. Color of the blood?
3. Is the blood on the surface of the stool or mixed with the stool?
4. How long has the patient been bleeding?
5. Does the bleeding occur with, before or after defecation?
6. Is diarrhea present or absent?
7. Are there any contributory signs or symptoms?

The quantity passed is variable according to the patient involved. Some report each fleck of blood. Extreme to this are those who pass large amounts with little or no concern. It is well, in taking general history to inquire if the patient looks to see if gross blood has been passed. A backward glance before flushing the bowl may be life saving. Also there is the occasional color blind individual who cannot tell if there is bleeding. One should think of total blood volume when discussing rectal bleeding. In an infant the blood volume is estimated at 100 ml. per kilo, thus the loss of 30 ml. in a six and a half pound baby would be equal to over 600 ml. in an 150 pound adult. It is possible to underestimate both the quantity of blood loss, and the rapidity of the loss. The aim of treatment must be to arrest the bleeding, replace the loss, and cure the disease causing the blood loss. The color of the blood will often indicate the closeness of the lesion to the anus except in massive upper GI hemorrhage where sometimes the blood will come through unaltered. Bright red blood usually indicates a lesion in the rectum or colon. Melena or tarry stools are associated with lesions of

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the upper GI tract, cirrhosis of the liver, biliary atresia, and hemorrhagic disease. Blood from the stomach or small bowel is usually brown from the action of the HCl acid in the stomach. The same is true when the bleeding is from a Meckel's diverticulum, as the ulcerated area is usually ectopic gastric mucosa in the diverticulum.

Blood on the surface of the stool indicates a lesion in the rectum or sigmoid where colonic peristalsis has not mixed the blood with the stool. Lesions of the right half of the colon will be masked by slow bleeding which becomes mixed with the stool, as the contents are liquid in that area.

In cases of severe bloody diarrhea we suspect conditions such as bleeding Meckel's diverticulum, polyps, and intussusception. In diarrhea with only occasional bloody stools we suspect enterocolitis, ulcerative colitis, and proctitis.

Associated symptoms of abdominal pain, vomiting, nausea, cramps or the picture of shock are of great importance and should alert the physician to the possibility of silent bleeding from Meckel's diverticulum, intussusception, volvulus, mesenteric thrombosis or diverticulosis.

To determine the course of rectal bleeding it is necessary to consider the local causes of bleeding from the mouth to the anal orifice.

Mouth

In infants from mother's fissured nipple, or other trauma to mouth. In adults hemorrhage from gums, carcinoma of the tongue or mouth, or other trauma.

Nose and Pharynx

Secondary to trauma, occasional pharyngitis.

Esophagus

(A) Esophageal varices, particularly in the presence of splenomegaly and cirrhosis of the liver, (B) peptic ulceration, and (C) trauma—foreign bodies, chemical irritants.

Stomach and Duodenum

Peptic ulcer is the most common cause of upper GI bleeding in the adult. Hematemesis and melena of the newborn may be from acute peptic ulceration. At times, signs and symptoms of pyloric stenosis in two to four months old children may be from peptic ulcer. (1) Peptic ulcer secondary to extensive burns, (Curling's Ulcer); (2) gastritis—due to corrosive agents or non specific gastritis, which usually is of short duration and accompanied by cramps, vomiting, and diarrhea; (3) diaphragmatic hernia—hemorrhage may be from the herniated portion of the stomach. Gastric cancer is to be differentiated in cases of pernicious anemia.

Small Intestine

1. *Meckel's Diverticulum*—one of the chief causes of bleeding from the small bowel. Gross in reporting 149 cases Meckel's diverticulum massive bleeding was the chief symptom in 50 children, 80 per cent of these being under two years of age. The bleeding almost invariably comes from peptic ulceration at the neck of the pouch or of the mucosa of the ileum near by, due to the actions of the hydrochloric acid, and pepsin produced by aberrant gastric mucosa in the diverticula.² This type of bleeding is usually sudden, severe, and painless, and in a child who was previously well. The hemorrhage is usually serious and although the first stool may be tarry the following are bright red. The absence of pain is important in differentiation from intussusception.

2. *Intussusception*—more commonly found in infants and young children. Has characteristic onset of recurrent colicky abdominal pain, often very severe, and associated with the passage of bright red to a dark brownish mucoid material by rectum as late as 12 hours after onset. A history of repeated severe abdominal colic, a palpable abdominal mass, and characteristic "currant jelly stools" make the diagnosis definite. The cause of intussusception is usually a Meckel's diverticulum, lymphoma, polyps or hematoma.

3. *Duplication of portion of the alimentary canal*—may occur from mouth to anus, and is more common in small bowel. If duplication lies within the leaves of the mesentery it may impinge on the blood supply, and cause necrosis with sloughing and bleeding, or the duplication may have gastric mucosa that ulcerates.

4. *Volvulus*—if the bowel becomes twisted upon the mesentery so as to interfere with the blood supply, necrosis and slough with bleeding may result.

5. *Regional enteritis and enterocolitis*—recurring bouts of abdominal pain, occasional vomiting, and diarrhea with blood in the stools is characteristic.

6. *Parasitic infestation*—rarely causes blood grossly visible but chemical or microscopic examination will often show blood in the stool.

7. *Polyps—single or multiple*—Single polyps more often in the sigmoid and rectum. When multiple polyposis is present should check other members of the family for polyps. Bleeding from polyps occur with necrosis of the polyp, surface abrasion or malignant degeneration, and the amount is variable. Bleeding from polyps located in the colon or rectum is often more severe, and accompanies or follows defecation.

Large Intestine

Like the small bowel, the colon may have any of the above, and in addition one must think of carcino-

RECTAL BLEEDING / Robinson

ma, diverticulosis, and chronic ulcerative colitis. Although more common in adult life, ulcerative colitis does appear in childhood, and may be severe and fulminating or chronic. Jackman reported approximately 11 per cent of 871 patients with ulcerative colitis were children, one to five years old.³ During the period of diarrhea the stools may contain large amounts of mucous, blood, and pus, and over a period of time the blood loss may be extreme. Benign and malignant neoplasms including hemangiomas do occur in the large bowel or higher up, and may be the source of bleeding.

Anus

Anal fissure is the most common cause of unaltered blood in the stools of children. This bleeding is usually bright in color, streaks the stool, on the tissue, and occurs with or following bowel movement. The pain is usually severe, and burning in character. Other causes of bleeding from the region of the anus are hemorrhoids, fistula, proctitis, papillitis, cryptitis, rectal prolapse, and trauma from inserted foreign bodies.

Systemic Disorders That May Cause Bleeding

1. Hemorrhagic disease of the newborn, frequently the cause in the neonatal period, and usually responds to vitamin "K" therapy.

2. Purpuras—nonthrombocytopenia and thrombocytopenia.

3. Hemophilia—deficiency of clotting factors; family history.

4. Scurvy.

5. Leukemia.

6. Familial telangiectasia.

Chemical poisons and food allergy or dyscrasia may be the cause of bleeding. Medicinal iron, especially in early life, phosphorus and arsenic can cause rectal bleeding. Milk allergy is not an infrequent cause of bright red streaking in the stool in infancy, and is usually accompanied by colicky pain.

In adults as in children the cause of bleeding may be local or general, but must be considered as cancerous until proven otherwise. The most common cause of unaltered blood in the adult is hemorrhoids. This bleeding occurs with or following defecation, is variable in amount, and ceases spontaneously. The second cause of rectal bleeding is polyps. Benign polyps may occur anywhere from stomach to anus and bleed in varying amounts.

Neoplasms of the rectum, sigmoid or remaining colon usually bleed sometime in their development. Early bleeding may be intermittent, and then later after ulceration occurs will be serosanguineous. Low

lying lesions produce bright red blood while higher lesions produce tarry stools or occult blood.

Lesions of the cecum particularly have only occult blood until late in the stage of degeneration. Other causes not listed above that occur primarily in the adult are bleeding from diverticulae, carcinoid of the small bowel, rupture of sclerotic blood vessels, mesenteric thrombosis, hepatic disease, lymphogranuloma venereum, tuberculosis, excoriated pruritic skin, and condylomata. Horner of St. Louis, in reporting 75 cases of diverticula disease representing several hundred attacks, lists bleeding in four per cent of the cases.⁴ It is difficult to clinically diagnose diverticulosis with bleeding unless the following is present: passage of gross blood by rectum—often intermittent, diverticulae demonstrated by barium enema, and the absence of other intrinsic lesions of the intestinal tract or rectum.⁵ In diverticula bleeding the amount lost is usually small or moderate but in some cases has been massive. Hoar and Bernhard⁶ state that most of the patients who have massive bleeding are over 60 years of age, and frequently have arterial hypertension. Despite the fact that it has been deemphasized in the past, it has now come to be accepted that large bowel hemorrhage, sometimes of a severe nature can and does arise from a colon with diverticulitis.^{6,8,9,10} Patients presenting with this disease are fairly characteristic, usually physiologically aged, hypertensive, and arteriosclerotic, often with metabolic disturbance, and previous episodes of diverticulitis. If operated on during the bleeding episode the colon will be found filled with blood from the cecum to the rectum, small bowel usually clear, and the presence of multiple diverticulae on the colon. Utilizing multiple colotomies, and coloscopy the bowel is emptied of blood, then frequently the bleeding diverticulum can be visualized, and is more frequently found to be proximal to the sigmoid. These patients can be treated either surgically or conservatively. In the patients with massive hemorrhage that does not abate, and is becoming exsanguinated then surgical intervention is mandatory as a life saving procedure. Surgical diverticula bleeding is massive, severe, and of much greater quantity than associated with large bowel tumor or polyps. Patients with less massive bleeding can be treated conservatively, however, the incidence of recurrence is rather high, and in many instances serious sequela will develop. Elective surgery for recurring episodes of bleeding is quite feasible. Quinn and Ochsner⁵ report six cases of elective surgery with no bleeding noted on follow-ups. In the severe bleeder that requires more than 1500 cc. of blood to be stabilized, surgery should be performed to isolate the bleeding point. For the patients who bleed moderately and stop, two cri-

teria are proposed for elective surgery; the presence of overt shock during the bleeding episode and loss of more than 40 per cent of their blood volume.¹⁰

Carcinoma of the right half of the colon should be suspected, and ruled out in persons with the following symptomatology:

1. The chronic dyspeptic, who is often misdiagnosed as chronic appendicitis or chronic gall bladder pathology.

2. Those with anemia and weakness.

3. Those who complain of mass in the side, or in whom an asymptomatic mass is found during routine examination. Usually at this stage the tumor is readily diagnosed by use of the barium enema x-ray examination, and by determining the anemia is secondary and not pernicious in type. Rosser reports in 100 cases of right sided lesions 66 per cent had moderate anemia, and severe anemia in 30 per cent. Lesions of the left side of the colon are inclined to be of the encircling type causing progressive stenosis. It is in this part of the colon that fecal content is formed and hard, and in passing through the stenosing segment, may become streaked with blood. Little confidence is to be placed in the presence or absence of occult blood in the stool. If the blood is red, if it is in the stool or on it, and persists on repeated examinations, one may expect to find a lesion in the vicinity or distal to the splenic flexure. Bleeding is recognized as the most significant first indication of cancer of the rectum. However, it may not be the first sign as months may elapse before the growth penetrates the mucous membrane, and causes bleeding. The actual amount is usually small, and anemia not marked except in advanced cases. Buie of the Mayo Clinic in 1,937 cases obtained a history of bleeding in 84 per cent.

Early Detection of Cancer

Prevention of cancer is a controversial subject but early detection is not. If a group of women over 45 years of age, and men over 50 were carefully examined for cancer how many cases would be found? A recent study at the University of Minnesota Cancer Detection Clinic, reports one in 36; pre-cancerous lesions were found in one out of two.⁷ These patients numbered 8,229 over a nine year period, and were selected because of age group, and did not present any symptoms. The over-all survival rate of these was 68 per cent in comparison to a national average of 25 to 30 per cent. This shows the importance of careful examination in this age group. They further report that 25.8 per cent of the cancers found were on recheck annual examination. More significant in this study was the number of precancerous lesions in 4,279 of the 8,229 patients. These lesions being classified as rectal and colonic polyps,

leukoplakia, senile keratoses, krausosis vulva, gastric polyps, thyroid adenoma, in order of frequency. Survival by organ systems show best results in lesions of the gastrointestinal tract. With these facts in mind one can state that any prevention of carcinoma of the colon and rectum can be only aimed at the predisposing factors. This would mean the destruction of the polyps whenever found, and removal of the colon in cases of advanced ulcerative colitis or diffuse polyposis.

To accomplish a diagnosis of malignancy of the colon or rectum, we must be alert to the fact that a change in bowel habits and rectal bleeding are the earliest signs and symptoms. Repeated sigmoidoscopic and x-ray examinations should be performed until the source of the bleeding has been determined.

To await the appearance of the classical textbook symptoms of abdominal malignancy such as marked loss of weight and strength, profound anemia, dehydration, palpable masses, and severe pain is merely postponing the diagnosis until generalized metastasis has occurred, and there is no hope for cure. To quote Daniel Fisk Jones, "There is no disease that can be diagnosed with more accuracy than cancer of the rectum after the patient once presents himself, and yet there are few diseases which are diagnosed so late in their course."

Summary

The more common causes of rectal bleeding in children and adults have been enumerated. A thorough attempt should be made in all instances of gastrointestinal bleeding to establish the source of the blood. In adults in particular this should be done to rule out malignancy as the causative factor.

340 Boulevard, N.E.

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AN ATHEROGENIC PROFILE

Its use in the management of the coronary patient is described.

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ATHEROSCLEROSIS IS SAID to be the most common disease in America today and probably is responsible for more morbidity and mortality than any other single disease. Yet its etiology remains an enigma and the phrase "Atherogenic Profile" is in reality itself a misnomer. Since cardiovascular diseases account for more than five times as many deaths as any other disease it becomes imperative that, no matter how inadequate, some systematic approach should be used in the diagnosis and management of this disease.

A long-term epidemiological study of atherosclerosis is being conducted in Evans County, Georgia, population just under 8,000, where the incidence of death due to coronary thrombosis appears to be four times greater in the white than the Negro race. It is hoped, by studying matched groups, where there are coronary mortality differences, a better understanding of its etiology may be provided. The areas of diet, cholesterol, beta lipoprotein, body build, occupation, family history, blood pressure, blood coagulation, and pathological data obtained from autopsies are now being studied or hope to be studied in the near future. Approximately 9,000 serum cholesterol and 6,000 beta lipoprotein by electrophoresis determinations have been made to date. The following preliminary observations have evolved from this study. Before attempting to devise an atherogenic profile, let us first define the disease itself, review factors implicated in its etiology, and its incidence. What is the nature of the disease that prophylactically and therapeutically, we are trying to treat?

In a basic sense, it is a disease of obstruction, for its morbidity and mortality is due to diminished

caliber or complete occlusion of the blood vessel lumen. This obstructive process may arise from the vessel wall or blood within the vessel, or a combination of both. This broad definition encompasses many varied pathological processes which have been lumped together under the term arteriosclerosis. Those lesions which contain lipid material and involve the intima have been called atherosclerosis. However, atherosclerosis itself, is indeed a complex disease which possesses many variable forms. To the epidemiologist or clinician, a patient may have died from acute coronary thrombosis. But to the pathologist, the same patient died from a specific type occlusive lesion.

Let us now look closer at these lesions. First, those that may arise from the vessel wall itself.

Basic Lesion of Atherosclerosis

The basic lesion of atherosclerosis is one of injury or a foreign body reaction to the accumulation of intimal lipids. The general features include lipids in the intima and its foreign body reaction with the occurrence of macrophages, lymphocytes, mononuclear cells and the reparative processes of fibroblastic tissue.¹ Around this basic lesion are found secondary degenerative or proliferative changes.

These changes may extend from the intima into the media or adventitia. Connective tissue which is composed of fibroblasts, ground substance or mucopolysaccharides, collagenous, elastic, and reticular fibers is intimately involved in all of these lesions. Degeneration may occur in a number of ways. There may be (1) simple necrosis, (2) hyalinization or true scar formation, and (3) mucoid degeneration which is characterized by accumulation in the connective tissue of acid mucopolysaccharides such as

From Hames Clinic and The Evans County Health Department. This investigation is being supported by a grant from the National Heart Institute, U. S. Public Health Service.

Presented at the *105th Annual Session of the Medical Association of Georgia, May 18, 1959, Augusta, Georgia.

seen in rheumatic fever, myxedema, diabetes and other conditions. This can occur with or without proliferation of fibroblasts. (4) Amyloid degeneration which is characterized by deposition in the ground substance of material which stains much like collagen and mucin. (5) Fatty degeneration (6) calcification or (7) allergic proliferative fibroblastic changes as may be seen in myxedema, subacute allergic states, scleroderma and other conditions.² Other vessel changes may include excessive vascularized thin wall capillaries which tend to rupture and produce hemorrhage into the vessel wall. Added further to these complex lesions are pathological changes which occur from the blood itself.

There may be thrombi formed principally of fibrin or blood, (a) organization and incorporation into the arterial wall of small thrombi which result in intimal thickening or (b) infarction secondary to thrombosis. The anatomical position or proportions of ingredients in these lesions can in no way be predicted and depend on many different factors.

Atherosclerosis, therefore, to the pathologist is seen as having many different types of lesions, while it is seen by the clinician as a single disease entity which is an expression of the functional state of the disease's many complications.³ This may be illustrated by the following example: If a patient has severe atherosclerosis but no clinical manifestations, then to the clinician he is considered "normal". Yet, if this same patient's severe atherosclerosis produces functional incapacity by angina pectoris, then he is classified as having coronary heart disease. It has been this apparent health in the presence of severe disease involvement that has made it most difficult to find normal controls, predict its natural course or define adequate therapy and prevention.

The obvious conclusion from this discussion suggests there is no single etiological basis to explain the multiplicity of lesions. What then are some factors that have been implicated in the etiology of these lesions? As has been pointed out, the basic lesion is one of injury and repair.

Ways Wall May Be Injured

The wall can be injured by increased: (1) intravascular pressure (hypertension), (2) anoxia (severe anemia, shock, chronic pulmonary disease, marked bradycardia), (3) infection (rheumatic fever, syphilis, brucellosis, etc.), (4) trauma, or (5) by the accumulation of lipids.

The accumulation of arterial lipids has been variously ascribed to filtration, thrombus organization, and inclusions in the arterial wall, precipitation, wandering macrophages, etc. However, the demon-

stration by Siperstein, et al.,⁴ of the arterial wall's ability to synthesize its own lipids has provided a new concept for its accumulation. There probably are local and systemic factors which normally control the rate of this synthesis and maintain blood vessel wall integrity. When there is excessive synthesis, diminished utilization or disturbed metabolism at a focal point, atherosclerosis may evolve. A portion of the Evans County Study is devoted to studying factors which may regulate lipid metabolism. The earliest lesion of atherosclerosis appears to be disturbed metabolism of the connective tissue. These consist of simultaneous proliferation of the subendothelial fibroblast, fragmentation of the internal elastic membrane, and increase in the mucoid ground substance.⁵ Connective tissue metabolism is thought to be regulated by enzymes (hyaluronidase), vitamins (ascorbic acid), and hormones (thyrotropic and steroid⁶). Diabetes mellitus is also thought to adversely affect mucopolysaccharide metabolism. Elevated uric acid levels may be associated with diabetes because alloxan will produce permanent diabetes in animals and alloxan is chemically related to uric acid.⁷

Allergic fibroblastic proliferation is thought to be related to antibody production or faulty production of protein by plasma cells.⁸

Some implicated reasons for thrombus formation arising from the blood have been excessive production of fibrinogen—failure of normal fibrolysis, polycythemia vera, and stasis.

True Incidence of Atherosclerosis

What is the true incidence of the disease? When does it normally begin to occur? Dr. R. L. Holman in studying the natural history of atherosclerosis has demonstrated its universal occurrence in all individuals beginning at age three. He used the aorta, after staining and measuring its area of lipid involvement as an index of atherosclerosis for that individual. Over 1,000 aortas in all age groups from birth to old age have been studied in chronological order. The total area of aortic involvement takes a sharp increase around the beginning of puberty and almost reaches its maximum before the age of 20.⁹ This new reorientation suggests many interesting possibilities:

1. If atherosclerosis begins at age three, then cholesterol levels may not be as important as was once thought. Around 2,000 cholesterol determinations of individuals in Evans County under age 18 show cord blood levels begin at about 80 mg. per cent and gradually rise to about 180 mg. per cent by age 18. If atherosclerosis reaches its maximum area of aortic involvement at a time when serum

ATHEROGENIC PROFILE / Hames

cholesterol levels are well below 200 mg. per cent makes one wonder (a) what is the ideal serum cholesterol level, (b) does lowering serum levels *per se*, really retard the rate of atherogenesis?

2. The question of stress, obesity, tobacco, hypertension, occupation, diabetes, and many other factors would appear to be secondary causes since these certainly are not universally present in this age group.

3. Herein also lies hope for a valid atherogenic profile. Since the disease is universally present and its complications are responsible for most of its morbidity and mortality, then to determine and control the causes of its complications present a fruitful avenue to explore. In view of the multiplicity of factors involved in atherogenesis a total approach is necessary in devising an atherogenic profile. Since the direct cause or causes are not known, the indirect approach must be tried. That is, attempt to study as many factors as possible which are associated with an increased incidence of the disease.

Atherosclerosis Most Frequently Occurs

Atherosclerosis has been said to occur more frequently in individuals who have abnormal values in the following areas:

1. *Family history of cardiovascular disease.* Observations to date in Evans County suggest this is perhaps one of the most important single determining factors. To have been born and reared in the study county affords one the unique opportunity to view and intimately know three generations. When successive generations of a family occupy the same house and when sudden death from vascular accidents occur in succeeding generations in the same age groups and in the same surroundings, one is even more impressed with the role of heredity. In a family under observation in a nearby county, the grandfather and the father both died at age 35 from apparent coronary thrombosis. Now, the son has had a severe coronary thrombosis at age 33. Incidentally, extensive studies of his lipid values have all been repeatedly within normal range.

2. *Height-Weight.* It appears that obesity *per se* may not directly increase the incidence of atherosclerosis. Indirectly it appears to have an association because of increased metabolic demands of obesity. Some of the most severe atherosclerosis seen at autopsy have been in individuals who were underweight their entire lifetime.

3. *Body build.* This has not proven to be very selective in the Evans County study.

4. *Blood pressure.* Hypertension has been re-

ported to occur three or four times more often in those with coronary disease.¹⁰ This appears to be true in the Evans County study.

5. *Renal.* The nephrotic stage of chronic glomerulonephritis is accompanied by hypercholesteremia and early marked vascular degenerative changes.

6. *Thyroid.* Many studies indicate hypothyroidism may increase the tendency to coronary disease.¹²⁻¹³ Thyroid metabolism unquestionably plays an important role in vascular metabolism.

7. *Uric acid metabolism.* Gertler and others have reported elevated uric acid in post coronary patients.¹³

8. *E.K.G.* EKG findings when positive are very helpful, but one is continually impressed by the broad areas of pathology disclosed at autopsy which are not disclosed by the EKG.

9. *Carbohydrate metabolism.* It has been said, in the presence of diabetes mellitus the chances of death from coronary thrombosis are doubled.¹⁴ This would appear to be true from the Evans County study.

10. *Perivascular inflammatory disease.* Syphilis, brucellosis, malaria, and rheumatic fever are some inflammatory diseases which have been implicated in the pathogenesis of atherosclerosis.^{15,16,17,18}

11. *Collagen diseases.* (a) Scleroderma, (b) polyarteritis nodosa, (c) lupus erythematosus are all associated with increased atherosclerotic changes.

12. *Lipid metabolism.* Xanthelasma, xanthoma tuberosum, Xanthoma tendenosum, hyperlipemia, and hypercholesteremia have been reported to carry an increased coronary mortality rate and are thought to be genetically controlled.

13. *Beta lipoproteins.* Numerous workers have attempted to use beta lipoprotein levels as a predictive measure for atherosclerosis, such as Gofman's atherogenic index and alpha/beta ratio or beta lipoprotein levels. No test has been found in the Evans County study which proves to be predictive for the individual. The reason why becomes quite obvious when one considers that the measure of lipid levels, is only one of a multitude of factors which enter into the total picture. One cannot justly expect a single test to incorporate so many divergent factors.

14. *Anoxia.* Whether it be from anemia, pulmonary emphysema, or fibrosis.

15. *Emotional stress.* Though unquestionably emotional factors play a very important role in coronary disease, the current concept of the typical coronary patient as an aggressive individual who is continually striving for greater accomplishments, has not proven to be the case in Evans County. Many of our citizens who never showed any initiative in their lives have had severe coronary thrombosis.

16. *Blood.* The incidence of atherosclerosis and

arteriosclerosis appear to be about equal in the two races in Evans County. However, since the death rate appeared to be four times greater in the white race, this suggested the thrombus mechanism may play a part in this marked difference.

Dr. John O'Brien, a hematologist from Portsmouth, England is to begin a comparative study of coagulation mechanisms in the two races of Evans County this summer. He feels a new orientation is called for with effort directed towards abnormalities of damage in the blood vessel wall and the nature of the subsequent interaction between the area of damage and circulating blood. The Evans County study hopes to contribute to a better understanding of the thrombus mechanism.

Polycythemia vera, whether it be real or relative has increased viscosity, sludging, and increased tendency to thrombus formation.

Summary

The well treated coronary patient demands no less than complete and total medical management. For the disease we hope to prevent or cure is a multifaceted disease whose primary etiology is unknown and to equate its many ramifications does not appear probable at this time. However, by maintaining a normal state of weight, blood pressure, renal, thyroid, blood lipid, carbohydrate, purine metabolism, and develop a philosophy of emotional rapport with

ones surroundings may help to prevent or reduce the catastrophic sequela of its many complications.

4 North Newton Street

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GRADY COUNTY CLINIC NAMED FOR DR. COUNCIL H. MAXWELL

DEDICATION OF THE new Maxwell Clinic at Calvary, a thriving rural community center 15 miles southwest of Cairo, was recently held in a special program and "open house."

The modern clinic was named to honor Dr. Council H. Maxwell, a native of the Calvary community, who is now completing his 59th year of round-the-clock medical care over portions of four counties—Decatur and Grady in Georgia and Gadsden and Leon in Florida.

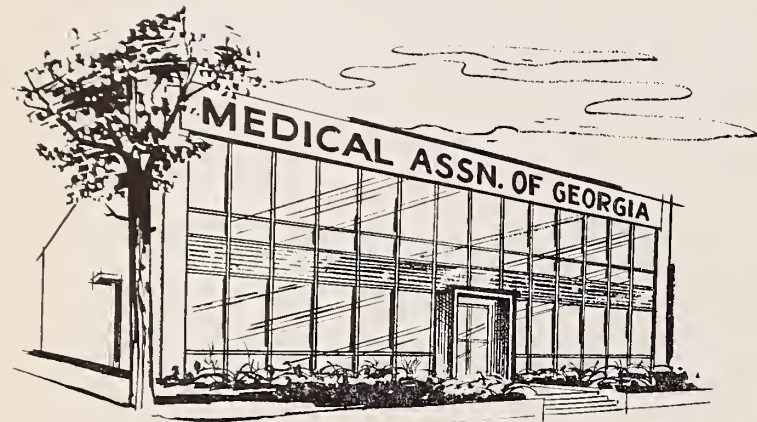
Last winter, during one cold night, he performed the unusual feat of delivering babies in each of the four counties. He still answers calls day and night just as he did in the "horse and buggy days" back in 1901, and prides himself in his record of never having refused to serve a person in need of treatment.

Dr. Maxwell has been publicly honored several times, particularly by the Medical Association of Georgia when he completed a half-century of practice. His long practice has never been interrupted by his own illness, although he did take time out once to serve Grady County in the Georgia Legislature. He also has served as county commissioner and as a district school trustee.

The dedication program was opened with the invocation by the Rev. A. Jay Wimberly, pastor of Calvary Baptist Church, and the dedicatory prayer was by the Rev. J. D. Corbitt Jr., pastor of the Calvary Methodist Church. In addition to music, there were several special presentations, and, preceding the "open house," there was a parade of babies brought into the world by Dr. Maxwell.

—Albany Herald

FROM DREAM TO REALITY



The dream of owning its own building has at last become a reality to the Medical Association of Georgia. The purchase of the Gulf Life Insurance building at 938 Peachtree Street was made January 1, 1960, and the final moving took place February 5, 1960.

Back in 1942, a resolution was adopted by the House of Delegates to set up a building fund to provide for the purchase of a building site. A certain amount of money was to be set aside each year for this purpose. Although the building fund grew each year, and many suggestions and ideas were brought up, the first real progress was made when the House of Delegates adopted a resolution in 1958 that empowered Council to purchase a building or building site.

Council appointed a Building Committee that went to work immediately to find a building or location that would best suit the needs of the Association. Many possibilities were investigated and each was considered carefully. Many long, hard hours were spent by this Committee in order to make the best possible selection. After weighing all of the advantages and disadvantages of each, the building found that would best provide for M.A.G.'s needs was the Gulf Life Insurance building. It was unanimously decided to purchase this building, if an agreeable price could be arranged. The Building Committee met with the Gulf Life Insurance officials and a compromise price was reached. During the 1959 Annual Session, the House of Delegates adopted the resolution that gave final approval for the purchase of this structure.

The Gulf Life Insurance Company vacated the property on December 31, 1959, and immediately contractors began making the necessary changes to accommodate the building to the needs of the Association. By February these changes were completed and the headquarters office was transferred from the Academy of Medicine on West Peachtree Street to its new location on Peachtree Street.

Besides its excellent layout, the appearance of the building is very attractive. The building is a two-story, red brick structure with plate glass windows facing Peachtree Street and is easily identified by the wording Medical Assoc. of Georgia on the front in large green letters. The lot measures 400 x 80 and has ample parking space for 50 cars in the rear of the building. There are two entrances to the



Executive Secretary's Office

Work Room for Supplies and Equipment





Night Picture of the Front of the Headquarters Office

parking area, one from Peachtree Street and the other from Cypress Street. The parking area can easily be enlarged, if future needs demand.

The interior of the building is most attractive and offers adequate working space. The structure contains approximately 6,000 square feet—3,000 square feet for offices and administrative area and 3,000 square feet for conference rooms, meeting hall, and storage. The first floor provides space for all offices, including Medicare. A workroom to accommodate machines and equipment, is also on the first floor. The second floor is designed to accommodate conferences, large meetings, and the Woman's Auxiliary,

leaving adequate space for storage. The building is well lighted, adequately heated, and completely air conditioned, making it comfortable at all times.

New desks and equipment have been purchased for the new quarters under the supervision of an office planning consultant. This has resulted in an efficiently arranged and attractively furnished headquarters office.

If you are one of the doctors that was unable to attend the Open House, held March 27, please make a special effort to come see *YOUR* building. Your time will not be wasted!

(Continued on next page)

Large Meeting Room





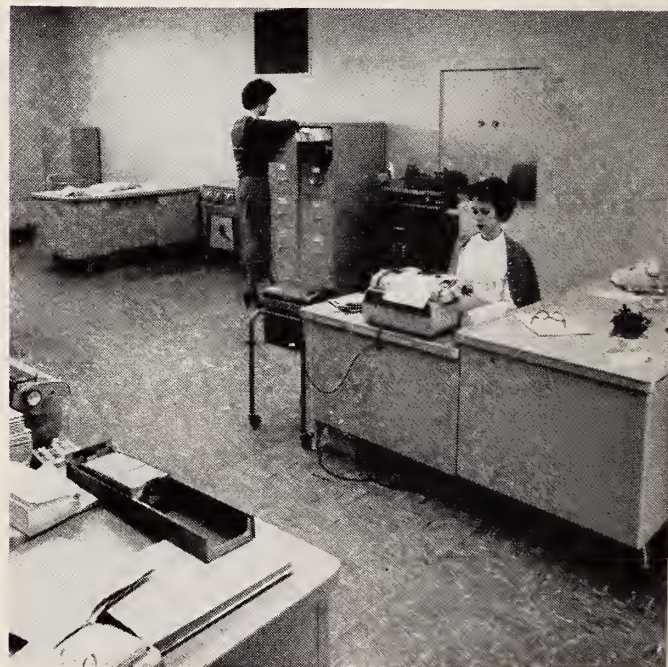
Parking Area



Business Office



Woman's Auxiliary Room



Reception Room

President's Office



The Journal Office



NEW MEMBERS OF THE MAG

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Abramson, Jerome H.	Grady Memorial Hospital Atlanta 3	Active	Fulton
Bittle, Charles R.	University Hospital Augusta	Active	Richmond
Brewer, John M., Jr.	384 Peachtree St., N.E. Atlanta 8	Active	Fulton
Cheney, Huddie L.	900 Gordon Avenue Thomasville	Active	Thomas-Brooks
Daniel, Ben E.	Metter	Active	Bulloch-Candler- Evans
Duke, Grady F.	232 W. Taylor Street Griffin	Active	Spalding
Ferrell, Wm. C.	Hall County Hospital Gainesville	Active	Hall
Goolsby, Sara L.	211 Andrews Street Rossville	DE 2	Walker- Catoosa-Dade
Hathcock, Earl Wm., Jr.	35 Linden Ave., N.E. Atlanta 8	DE 2	Fulton
Long, Harold G.	Dahlonega	Active	Hall
Merlin, Harvey E.	80 Butler Street, S.E. Atlanta 3	DE 2	Fulton
Morales, George A.	540 S. Hill Street Griffin	Active	Spalding
Nalley, James L.	Patterson	Active	Ware
North, Luceil B.	35 Linden Ave., N.E. Atlanta 8	DE 2	Fulton
Saffan, Benjamin D.	69 Butler Street, S.E. Atlanta 3	DE 2	Fulton
Sessions, Howard K.	Ga. Dept. of Public Health Atlanta 3	Active	Fulton
Swann, Julian W.	1968 Peachtree Rd., N.W. Atlanta 9	DE 2	Fulton
Tanner, Clyde V.	204 N. Cromartie Hazlehurst	Active	Altamaha
Tillman, Samuel P.	80 Butler Street, S.E. Atlanta 3	DE 2	Fulton
Upshaw, Charles B., Jr.	U. S. Army Hospital Ft. McPherson	DE 2	Fulton
Williams, Jay D., Jr.	1968 Peachtree Rd., N.W. Atlanta 9	DE 2	Fulton
Wood, J. Edwin	Medical College of Georgia Augusta	Active	Richmond



editorials

New Headquarters Building

THE ACQUISITION OF THE new Headquarters Office Building on Peachtree Street marks a true milestone in the history of the Medical Association of Georgia. As long ago as 1942 the need for a separate headquarters office building was foreseen and a building fund was established. Through the years with the growth of this fund the need for extra office facilities grew apace. During the past decade the question of a separate headquarters office building was brought up from time to time but no definite conclusions were reached.

Three years ago with the space problem having reached the acute stage, it was agreed to begin active investigation of building sites and other possibilities. During the past three years it is likely that your building committee spent hundreds of hours in ne-

gotiations, planning, and the tedious details of moving to larger quarters. This committee with its capable chairman deserves the unqualified praise of every member of the association, for they have by careful planning selected for the Medical Association of Georgia a facility which will adequately serve the expanding needs of the association for many years to come. It is a structure to which we may all point with pride not only for its excellence but because it is reputed to be the only building that has been purchased or built by a state association without an additional assessment of all members.

Please come in and inspect your new headquarters office building, doctor. We believe you will be proud of it.

The Phenolsulphonphthalein Test

THE P. S. P. KIDNEY function test is often unjustly maligned as worthless unless renal insufficiency is obvious. If the P. S. P. test is properly employed and correctly interpreted, it can be very useful especially in milder cases of renal failure or in instances of recovery from acute renal failure.

The renal nephron or unit consists of the filtering portion glomerulus, with the proximal convoluted tubule, loop of Henle, distal convoluted tubule, and collecting tubule. A rise in BUN or NPN suggests either a general failure of the kidney or a filtration problem such as in glomerulonephritis, lupus or

periarteritis. A fall in P.S.P. output occurs in general nephron failure but if isolated suggests a decrease in blood flow or disease of the proximal convoluted tubule. A fixed specific gravity points to trouble in the distal nephron.

The vast majority of patients who come with symptoms of renal failure have all modalities of function severely depressed. However, if one studies all patients with signs, abnormal urinary findings, and those who have diseases known to be associated with kidney involvement, disparities between the three functions mentioned above become apparent.

For instance, in approximately one half of the cases of acute glomerulonephritis the renal blood flow is unaffected so that the P. S. P test remains relatively normal while the diseased filtering membrane of the glomerulus causes a rise in NPN. At the same time the distal part of the nephron is able to maintain a specific gravity in the urine of better than 1.020.

In both pyelonephritis with renal failure and acute tubular necrosis (lower nephron syndrome) the P. S. P tests and specific gravity become depressed because of the primary tubular damage although in the former the specific gravity may be good for the first 24 hours.

In patients with hypertension, a good P. S. P test does not rule out renal ischemia as the cause but a sharp reduction in P. S. P output in benign hypertension of only a few years duration strongly sug-

gests primary renal origin of the hypertension.

The most amazing case of disparity of renal function the author has seen, was one in whom the NPN was normal, the one hour P. S. P output zero, and the specific gravity of the urine 1.024. The knowledge that sodium is reabsorbed by the proximal convoluted tubule in the same proportion to chloride and bicarbonate as is found in the blood would make one suspect that this was one of the rare cases of salt-losing nephritis. It was very interesting to find that this was true.

Thus, if one does all of the clinically feasible renal function tests in all patients with any findings of renal disease, the changes may be helpful. In advanced renal failure, the P. S. P and other tests are of little value once the diagnosis of renal failure is established.

Regional Conference for Health Care of the Aged

ONE OF THE PROBLEMS in any approach to health care of our aging population is that factors other than medical progress are involved. The primary interest in aging is always health, but it is clear that the health of older people depends on social, economic, and vocational needs as well as medical needs.

To point this up and stimulate interest and participation of all segments of the public in meeting these underlying needs, the American Medical Association in cooperation with state medical associations has been holding a series of regional conferences throughout the country. The most recent conference, held in Atlanta and cosponsored by MAG and five other southern states, was attended by approximately 400 representatives of medicine, women's organizations, churches, labor, industry, and government.

A number of Georgia physicians and laymen participated in the Conference, and they as well as other speakers are to be congratulated on the excellent program. The positive approach to aging problems was emphasized and the entire conference reaffirmed medicine's "positive program," the first point of which is "stimulation of a realistic attitude on aging."

The Conference accomplished this objective. Speaker after speaker referred to "adding life to years instead of just years to life." One speaker

said "I am convinced that if you will just sit and wait for death to come along, you will not have long to wait." Another said, "You can run to retirement or you can run from retirement. To retire *from* is tragedy, but to retire *to* may mark the beginning of the most satisfying part of your whole existence."

Individual responsibility was emphasized throughout the Conference. Government programs which would tend to reduce the aged to semi-dependent wards of the federal government were termed harmful by Dr. Leonard Larson, Chairman of the AMA Board of Trustees and luncheon speaker at the Conference.

Dr. Larson concluded, "Right now we are at the turning point in the drama of America's aged population. They can either stride forward with the help they are being offered, or they can sit back and hope for a handout. Personally I believe they want to cooperate, to help themselves. I know that senior citizens want only a hand, not a handout."

Community leaders attending this Conference felt they had gained assistance in designing projects and programs for their own hometowns to meet the total needs of the aged. These civic leaders were assured of medical support and guidance from the county medical society in each community. Because of medicine's great responsibility in this field, the profession must continue to stimulate interest in the aging and provide leadership when needed.



mental health page

SEXUAL PERVERSIONS

Tom W. Leland, M.D., *Atlanta*

THE INCIDENCE OF sexual perversion is usually higher than most of us prefer to believe and the local physician is often consulted by the victim, his family, and/or the police as an authority in this area of abnormal behavior. Human beings vary surprisingly in their knowledge about sexual deviations, and in much of the semipornographic data available to the layman misinformation abounds. The frequency with which the physician "happens upon" perversion cases depends to a great extent on whether or not he takes a rather complete history including a detailed sexual history. When a sexual perversion is detected the more the physician is educated in this field the better he is able to handle "the confession" with equanimity, and good rapport will be enhanced, making the psychiatric referral easier.

Sexual perversions can usually be classified as mild or severe depending upon the bizzareness, repetitiousness, and coexisting psychopathology (immaturity, neurosis or psychosis). The numbers of people suffering from the various types of perversions have not been (and perhaps will never be) accurately determined. In the following paragraphs most of the well known perversions are defined and briefly described.

Probably one of the most common of the sexual perversions is *voyeurism* or *scoptophilia* (peeping tom). Watching a burlesque show or glancing up at an apartment window while waiting for the bus may simply be curiosity. Repetitively performed it could be called voyeuristic, but to be classified as a sexual perversion there would be a large degree of "compulsion" in the act and the voyeurism would be a major source of the person's sexual gratification.

Exhibitionism is frequently coupled with voyeurism. The exhibitionist exposes his genitalia in public. The illness is almost limited to males and they are frequently impotent. If married, their wives frequently are frigid and overly modest. Psychologically the exhibitionist is saying, "Look at me . . . I'm a man . . . (aren't I?)" He performs his act impulsively and looks for shock or surprise or any sort of reaction in his victim's (the viewer's) eyes which temporarily reassures him.

Homosexuality is an extremely common sexual perversion and is, of course, not limited to males. Male homosexuals are often exceedingly masculine in appearance and mannerisms, and female homosexuals may appear quite feminine. Modern psychi-

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

atry thinks of homosexual development as being at least contributed to, if not actually caused by, life experiences that interfere with normal masculine identifications on the part of the boy and feminine identifications by the girl. The boy who is enveloped by a possessive and controlling mother may identify with and later emulate her; the boy who is passively indulged by a weak and possibly latently homosexual father may tend toward effeminacy and homosexuality. The essential normal requirement for the boy is association with a healthy masculine father, or father substitute, who, through identification, serves as a model for the boy's conception of himself. The same holds true with respect to the necessity for exposure to a normally feminine and motherly mother for the girl. Homosexuality is usually classified as overt or latent. Overt relations may consist of fellatio (oral-penis), sodomy or pederasty (penis-rectum) in males; cunnilinguism (oral-vulva) in females; or mutual masturbation in either sex. Latent homosexuality refer to conscious or preconscious homosexual desires which are not being acted upon. A person who is overtly both homosexual and heterosexual is usually called bisexual.

Fetishism is an uncommon form of sexual deviation, limited to males, in which the person's sexual drive (libido) is attached to some object that is a symbol of the "real" love object. The fetishist may be sexually attracted, obsessively so to a woman's

undergarment, shoe, glove, lock of hair, etc.

Frottage is a form of sexual deviation in which orgasm is obtained by touching or rubbing against a woman's body usually the buttocks.

Transvestism refers to preferential wearing of the clothing of the opposite sex. Although closely related to homosexuality, the transvestite may not be overtly homosexual. There are frequently fetishistic and masochistic features in the illness and occasionally newspapers carry the story of a male dressed in woman's clothing and make-up was apparently accidentally hung while attempting masochistic self-strangulation (there have been such deaths in Georgia in the past year or so). Transexuality occurs when the transvestite seeks sex transformation surgery in a effort to further masquerade as the opposite sex.

Sadism and *Masochism* are two separate perversions in which the sexual gratification is achieved by inflicting cruelties (sadism) or receiving pain and cruel treatment (masochism). These perversions are not rare. The patients may be rather incapable of having sexual gratification except by spanking, whipping or verbal abuse.

Zoophilia or *bestiality* is a perversion in which the person (male or female) receives sexual gratification from sexual relations with sub-human animals.

In *necrophilia* (necromania) the patient receives sexual gratification from manipulation or copulation with corpses.

A NEW INTEREST IN POLITICS

DURING THE PAST year businessmen and business groups have been awakening in great numbers to a long-felt need. That need is for the business community to actively enter into political activities all the way from the city hall to the national capital.

Leaders of both the parties have welcomed this development, saying it should lead to better government.

Business people, like labor, agricultural, and other groups, have the responsibility as well as the right to make their views known.

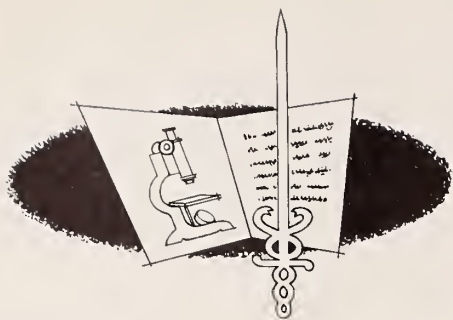
Now Dr. Louis M. Orr, president of the American Medical Association, urges that the nation's doctors

"take a more active interest in the whole area of politics, public affairs, and community life."

He adds: "A physician cannot, if he values this nation's high standard of medical care, divert his gaze from the social, economic, and political issues which affect the practice of medicine."

Every segment of American society today is directly affected by political problems and activities. And every segment has the duty to enter the political arena, frankly and openly, and present its case to that court of last resort—the American people.

—Waycross Journal Herald



cancer page

GIANT PUBLIC EXHIBITION ON CANCER

R. M. Reifler, M.D., *Macon*

DURING A SIX-DAY period last September more than 25,000 persons—an average of about 400 an hour—threaded their way through the Exhibition Hall at Macon's Central City Park to view what may probably have been the largest exhibition on cancer ever presented for the general public.

Entitled "Crusade for Life", the giant exhibition was co-sponsored by the American Cancer Society's Bibb County Unit and the Bankers' Health and Life Insurance Co. Admission was free and there was no solicitation of funds.

Endorsed by the Bibb County Medical Society and Dental Society, "Crusade for Life" aimed to convince everyone who attended (1) that most early cancer is curable, (2) that the methods of diagnosis and treatment of cancer are neither mysterious nor painful, (3) that incurable cancer is just that; quackery is of no value, and (4) that every doctor's office is a cancer detection center.

Nine months of pre-planning and work involving more than 500 volunteers went into this cavalcade of exhibits. Most of the exhibits were prepared locally, but others came from Atlanta, New Orleans, New York, Birmingham, and Halstead, Kansas.

Cancer sites covered in the exhibits included cancer of the head and neck, skin, oral cavity, eye, larynx, lung, breast, thyroid, bone, urinary tract, digestive tract, uterus, central nervous system, moles and melanomas, and leukemia. Other exhibits were devoted to cancer research, the "seven danger signals," value of periodic examinations, cancer quackery, x-ray and radium, rehabilitation of cancer patients, cancer clinics and services, the A.C.S. "Gift & Loan Closet," tissue diagnosis, Papanicolaou smears, frozen sections, blood bank and typing, and

a first-aid booth. In addition, a complete hospital operating room was set up for examination by the viewers.

The individual booths were attended by physicians, dentists, nurses, and technicians to explain the exhibits and answer questions. Members of the Medical Auxiliary served as hostesses.

Weeks before the exhibition opened, a publicity barrage was extended throughout Middle Georgia. Newspapers, radio, television, schools, church groups, civic and social organizations, military installations all participated in spreading the work. And it paid off in bringing people from throughout that section of the State into Macon to view the exhibits.

The full results of this project are not known, but the sponsors felt that the public accepted such an exhibition and that it was an excellent vehicle to educate people about cancer and the value of early diagnosis.

The response for volunteers was gratifying and brought new individuals into the common fight against cancer. Also, "how-to-do-it" requests have been received from other parts of the nation from people who are considering a similar project for their communities.

The Board of Directors of the American Cancer Society's Georgia Division unanimously passed a resolution commending the Bibb County unit and the Bankers Health and Life Insurance Co. for their efforts in connection with the project.

Complimentary comments on the value of the exhibit are still being received. People have not forgotten the effort put forth in their effort.

Approved by Professional Committee, Georgia Division, ACS.

current clinical concepts

Splenectomy in ITP

SPLENECTOMY IS NO LONGER practiced for primary thrombocytopenic purpura at the Amsterdam Pediatric Clinic according to Dr. Simon van Creveld at the University of Amsterdam. Although a significant rise in platelets occurred following splenectomy in this condition the platelets were found to show significant disturbances in their functions.

Creveld, Simon van: Report to the Amsterdam Society for Advancement of Natural, Medical, and Surgical Sciences.

Amethopterin in Acute Leukemia in Children

INFREQUENT LARGE DOSES of amethopterin parenterally has been used with value in the response in children who have been treated with the anti-metabolites in daily and prolonged regimes and have become apparently resistant to this mode of treatment. Dosages of 1-5 mg/Kg of body weight at 2-4 week intervals are indicated.

Condit, Paul T., and Eliel, L. P.: Effects of Large Doses of A-methopterin on Acute Leukemia in Children, J.A.M.A. 172(5): 451-453, January 30, 1960.

Staphylococci Infections

IN A PANEL DISCUSSION of staphylococci infections, Dr. Wise reported studies that showed 66 per cent resistant strains in infections in people who had no contact with hospitals were sensitive to penicillin, or at the other extreme, 100 per cent resistant strains in people who had some contact with hospitals, either as a patient or as a relative of some hospital worker, were resistant to penicillin.

From a talk at the American College of Surgeons meeting held in Atlantic City, N. J., September 28, 1959-October 2, 1959.

Intravenous Aortography

IN 110 PATIENTS, 122 aortograms were performed using the intravenous application Hypaque® and Renografin®. There were no deaths or serious complications in this group and studies of diagnostic quality were obtained in over 90 per cent of the cases reported on. This included patients with aortic aneurysms, occlusions, post operative aortic grafts, and various renal lesions. It was felt by the authors that the complications of translumbar aortography secondary to direct blind aortic puncture will be eliminated by this method.

Bernstein, Eugene F.; Greenspan, Richard H., and Loken, Merle K., M.D., A.M.A. Archives of Surgery, Vol. 80, No. 1: 71.

Thirst

WHEN ANDERSON AND MCCANN applied an electrical stimulus to a certain area in the hypothalamus near the supraoptic nucleus, the goats drank enormous amounts of water, and some of them diluted their body fluids so much that they lysed their own red blood-cells. If the same area was destroyed the goats would not drink even when they were dying from water depletion. Since some, but not all, of the goats in which thirst was abolished also developed diabetes insipidus, the thirst center must be closely related to the hypothalamic center for antidiuresis.

Fourman, Paul and Leeson, P. M.: Thirst and Polyuria, with a note on the Effects of Potassium Deficiency and Calcium Excess, Lancet 1:268, 1959.

Hernias, Hydroceles and Undescended Testicle

ALL CHILDREN'S HERNIAS are congenital. No trusses are needed and they never cure. Simple ligation of the cord of the sac is enough with reconstitution, as quickly and accurately as possible, of the tissues necessary to divide in order to ligate this sac.

C. Everett Koop, Philadelphia, from his talk at The American College of Surgeons Meeting in Sea Island, Ga., September, 1959.

A Study of the Current Pulmonary Embolism

RECURRENT EMBOLISM HAS occurred in 12 patients while on heparin therapy and in 24 patients while on coumarin therapy. Recurrence after discontinuance of anticoagulant therapy was noted in 28 patients constituting a definite indication for consideration of vena caval ligation. After vena caval ligation there was only one of the 21 patients followed who had a subsequent pulmonary embolus. The syndrome of recurrent silent pulmonary emboli in the absence of clinical evidence of venous thromboses in the extremities may constitute a difficult problem in diagnosis. Progressive enlargement of the pulmonary arterial outline at the hila and the gradual disappearance of peripheral pulmonary arterial tributaries are highly suggestive of this syndrome.

Schauble, James F., M.D.; Anlyan, Wm. G., M.D.; Deaton, Hugo L., M.D.; Delaughter, Geo. D., M.D.; Baylin, Geo. J., M.D., and Lynn, Jeanne A., R.N., Durham, N. C.



HEART FAILURE IN ACUTE NEPHRITIS

Joseph S. Wilson, M.D., *Atlanta*

MOST PATIENTS WITH acute glomerulonephritis become edematous, and about one in four develops the syndrome of congestive heart failure. In addition to edema, which characteristically involves the face, one may find cardiac enlargement, gallop rhythm, basilar rales, distended neck veins, and hepatomegaly. Patients may complain of dyspnea, but orthopnea is less commonly seen. On occasion, acute pulmonary edema may develop, especially in association with an acute hypertensive episode or a convulsive seizure.

It has been thought that there is a specific myocardial lesion in acute nephritis which causes the heart failure, but proof of this is lacking. At autopsy myocardial lesions are seen infrequently, and when present they usually consist of scattered areas of round cell infiltration, hardly sufficient to interfere with normal myocardial function. Electrocardiographic abnormalities are commonly present, but consist of non-specific ST-T wave changes and may be related to hypervolemia and electrolyte abnormalities in some instances. Nor can the edema be explained on the basis of increased capillary permeability, since the protein content of edema fluid in acute nephritis is low,¹ and edema resulting from increased permeability would have a high protein content.

Hypertension cannot be well correlated with the occurrence or severity of heart failure in acute nephritis. Heart failure may be seen in patients without hypertension, and in others it may subside

while hypertension persists. Except in those instances where acute pulmonary edema follows a hypertensive crisis, the elevated blood pressure is probably of little importance in the production of the congestive phenomena.

It has long been recognized that there is a normal or decreased circulation time in the heart failure of acute nephritis.² More recent studies³ have shown a normal cardiac output and arteriovenous oxygen difference. In these respects it differs from the usual case of heart failure, and resembles the "hypervolemic syndrome" as described by Eichna⁴ following corticosteroid therapy, in which the primary disturbance leading to the congestive phenomena is excessive salt and water retention. This is also commonly encountered in acute renal failure with excessive salt and water administration during the oliguric phase. In these instances there is no evidence that the heart has failed as a pump. The reduced glomerular filtration in the acute stage of glomerulonephritis sharply reduces the sodium load presented to still normal tubules which continue to reabsorb sodium. Thus sodium excretion is reduced, and in the presence of continued intake, salt and water retention occur, leading to the syndrome of congestive heart failure even though there has been no failure of the heart to deliver an adequate amount of blood to supply the bodily needs. In this sense "hypervolemic syndrome" would seem a more precise term than "heart failure."

It is much easier to prevent the hypervolemia

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

than to treat it once it has occurred. In acute nephritis, sodium salts should be eliminated from the diet and fluids restricted to a volume equal to the previous day's urinary output plus 600 cc. to account for insensible fluid loss. In the presence of congestive failure, somewhat less fluid should be given to achieve a negative balance, care being taken to avoid hypernatremia from too rapid dehydration. Digitalis therapy may not be effective, but should be tried in the presence of pulmonary congestion. When pulmonary edema occurs, oxygen therapy, venesection, rotating tourniquets, aminophyllin, and sedation are indicated. Removal of pleural effusions may improve dyspnea. Diuretics are ineffective and may be harmful. Ganglionic

blocking agents may improve pulmonary edema by increasing the capacity of the vascular bed. Fortunately, in most instances, diuresis occurs within a few days with rapid disappearance of the congestive phenomena.

References

1. Warren, J. V. and Stead, E. A.: The Protein Content of Edema Fluid in Patients with Acute Glomerulonephritis, *The American Journal of Medical Science* 208:618, November, 1944.
2. LaDue, J. S.: The Role of Congestive Heart Failure in the Production of the Edema of Acute Glomerulonephritis, *Annals of Internal Medicine* 20:405, March, 1944.
3. Davies, C. E.: Heart Failure in Acute Nephritis, *Quarterly Journal of Medicine* 20:163, April, 1951.
4. Albert, R. E.; Smith, W. W., and Eichna, L. W.: Hemodynamic Changes Associated with Fluid Retention Induced in Noncardiac Subjects by Corticotropin (ACTH) and Cortison; Comparison with the Hemodynamic Changes of Congestive Heart Failure, *Circulation* 12:1047, December, 1955.

CONGRESS WARNED TO WAIT

CONGRESS HAS BEEN WARNED against acting on legislation to provide health care of the aged before receiving the recommendations of next year's White House Conference on Aging.

Rep. Noah M. Mason (R., Ill.), ranking minority member of the House Ways and Means Committee which handles such legislation, put in the Congressional Record an exchange of correspondence with former Rep. Robert W. Kean (R., N.J.), Chairman of the National Advisory Committee supervising preparation for the White House Conference next January.

Rep. Mason said the correspondence "reveals the reason why Congress should await the results of the Conference."

"Let us not waste the \$2 million we have already appropriated to bring thousands of good minds together to suggest solutions to problems of our aging population," Rep. Mason said. "Certainly we should get the benefit of their advice rather than enact legislation in haste and without proper study."

Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association, also voiced this warning in a radio interview while he was in Washington for conferences with White House aides and Arthur S. Flemming, Secretary of Health, Education and Welfare.

Dr. Blasingame said that it would be "neither practical nor realistic" for Congress to act on such legislation until the White House Conference and other sources had compiled "more conclusive and complete information" on a nationwide basis.

Dr. Blasingame and other AMA representatives emphasized to President Eisenhower's aids and Flemming that the medical profession is unalterably opposed to any legislation, such as the Forand bill, that would use the Social Security system to provide health care for the aged.

In his letter to Mason, Kean predicted that "in all probability" most of the White House Conference's recommendations would be for "state and local activity" in dealing with the problems of the aged. Kean said that action at the state and local level "seems most effective."

The National Association of Manufacturers charged in a pamphlet that supporters of Forand-type legislation have exaggerated the health care needs of the nation's older people. The NAM pamphlet also said the Forand bill was an entering wedge for a cradle-to-grave compulsory health insurance plan.

Meantime, supporters of the Forand bill—particularly the AFL-CIO, continued an intensive pressure campaign aimed at Congressional approval of the legislation in this national election year when Congressmen are more susceptible to such pressure.

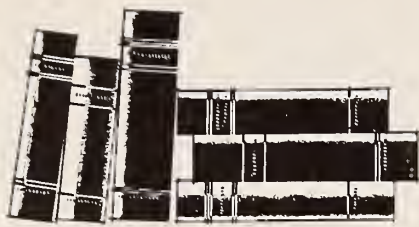
Another Democratic presidential hopeful, Sen. Hubert H. Humphrey (D., Minn.), reiterated his support for Forand-type legislation. He proposed a six-point program for aid for the elderly, including "an extension of the Social Security system to cover the cost of hospital and nursing home care for senior citizens."

Sen. John F. Kennedy (D., Mass.), a leading contender for the Democratic nomination for President, has introduced similar, but even broader, legislation.

Elsewhere on the national legislative front, prospects brightened for Congressional passage this year of a bill to permit physicians and other self-employed persons to set aside money for retirement.

The Administration, which last year opposed a bill with such provisions, appeared in mid-March to be ready to support it with modifications.

The Administration shift improved the already favorable odds that both the Senate Finance Committee, where a House-approved bill was pending, and the Senate would approve such legislation this session.



physician's bookshelf

BOOKS RECEIVED

Wilkinson, D. S., M.D., M.R.C.P., **THE NURSING AND MANAGEMENT OF SKIN DISEASES**, The MacMillan Company, New York, 1958, 288 pp., \$5.75.

Ariel, Irving M., M.D. and Pack, George T., M.D., **CANCER AND ALLIED DISEASES OF INFANCY AND CHILDHOOD**, Little, Brown and Co., Boston, 1960, 605 pp., \$22.50.

DeWeese, David D., M.D. and Saunders, William H., M.D., **TEXT-BOOK OF OTOLARYNGOLOGY**, The C. V. Mosby Co., St. Louis, 1960, 464 pp., \$8.75.

Modell, Walter, M.D., **DRUGS OF CHOICE 1960-1961**, The C. V. Mosby Co., St. Louis, 1960, 958 pp., \$13.50.

Council on Drugs of the American Medical Association, **NEW AND NON-OFFICIAL DRUGS**, 1960, The J. B. Lippincott Co., Philadelphia, 1960, 768 pp., \$3.35.

Roth, Arthur, M.D., **THE TEEN-AGE YEARS**, Doubleday & Co., Garden City, 1960, 288 pp., \$3.95.

Kobler, John, **THE RELUCTANT SURGEON**, Doubleday & Co., Garden City, 1960, 359 pp., \$4.95.

Marvin, H. M., M.D., **YOUR HEART: A HANDBOOK FOR LAYMEN**, Doubleday & Co., Garden City, 1960, 335 pp., \$4.50.

Birch, C. Allan, M.D., F.R.C.P., **EMERGENCIES IN MEDICAL PRACTICE**, Edinburgh, 751 pp., \$8.50.

REVIEWS

Gordon, Benjamin Lee, M.D., F.I.C.S., **MEDIEVAL AND RENAISSANCE MEDICINE**, Philosophical Library, New York, N. Y., 1959, 843 pp., \$10.00.

A COMPENDIUM SUCH AS Dr. Gordon has contributed to medical literature makes for difficult continuous reading but serves as an encyclopedia of source material for the medical historian from the fall of Rome in the mid-fifth to the final years of the 16th Century. Between the covers of this excellent reference work is both light entertaining bedside reading material and heavier, rather somewhat less than humorous historical data.

It seems that Dr. Gordon was unable to homogenize

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

his material. However, the layered effect has produced peaks and valleys of reader attraction and one is forced to state that the valleys are often as deep as the peaks are high. But the interested reader will find more peaks than valleys. The initial description of the Roman debacle is classic. Dr. Gordon's interpretation and insight, knowledge, and conclusions of those several hundred years of human depravement and degradation rivals that of Gibbon: "Education was no longer a standard of social distinction; wealth and political power became the only yardstick by which one was esteemed." . . . "where free men betrayed their patrons, and he who lived without an enemy died by the treachery of a friend."

Between these bits of intellectual morsels and the finale of the compendium is a list of some 1,500 individuals who have contributed in one way or another to the development of medical science and related areas. While more page references are listed beside the names of Galen, Hippocrates, Paul of Aegina, Rhazes, and Vesalius in this *Who's Who* of medical history, these number references need not be viewed as a yardstick of contributory importance. Indeed the significant contribution of such giants of the past as DaVinci, Leewenhoeck, Paracelsus, Harvey, and Ambroise Pare do not require page length dissertations for importance. Each of their contributions are singular epics as were those of many of the other 1,500 subjects of this tome.

So much was cloaked in mysticism and ignorance; so little knowledge of anatomy, biology, physiology, and chemistry was available during the 1,000 years covered that one becomes numbed by the reports of 10,000 deaths per day in Constantinople from the plague or an equal number of human beings that succumbed to small pox at a time when people still believed that menstrual blood was poisonous and syphilis acquired by divine wrath.

One of the most intriguing features, and indeed one which peaked the curiosity of the reviewer was the role played by those physicians who claim greatness in both medicine and literature. The renaissance humanist Linacre ably translated Hippocrates, Galen, and Aristotle from Greek into Latin and made the Latin more read-

able than the original Greek. The physician humanist and the renaissance reformer combined to lay the groundwork and to set the stage for the phenomenal growth and development of medical science that took place in the latter part of the 19th Century and the first half of the 20th Century. Dr. Gordon's masterpiece in one inclusive volume, has portrayed 1,000 years of medical history, the years which saw mankind emerge from the depths of superstition to an age of scientific enlightenment.

Peter L. Scardino, M.D.

Welch, Henry, Ph.D., and Finland, Maxwell, M.D., ANTIBIOTIC THERAPY FOR STAPHYLOCOCCAL DISEASES, Medical Encyclopedia, Inc., New York, N. Y., 1959, 208 pp., \$4.50.

THESE DAYS THE THERAPY of staphylococcal disease has come to demand the utmost ingenuity of the physician, requiring knowledge of many new antibiotics, their relative merits and toxicities, varying routes of administration, and so forth. To keep abreast of the rapidly changing field is likely to prove difficult for the busy physician. This volume attempts to review the information available on the newer important antistaphylococcal antibiotics: erythromycin, oleandomycin, novobiocin, vancomycin, ristocetin, and kanamycin, as well as summarize the role of more familiar antibiotics. Each of these is discussed by an authority who has worked with the drug. In general, the chapters are thorough, detailed, and well written although some are somewhat uncritical or overly defensive.

To leave it at this point would not help the reader much; moreover, most of the contributors seem to favor the antibiotic of their interest. It remains for Dr. Finland in the final chapter to summarize and compare in a restrained, conservative manner these diverse opinions and provide a basis for intelligent antistaphylococcal antibiotic therapy.

This volume is recommended as a reference work for those faced with the problem of treating serious staphylococcal disease.

T. F. Sellers, Jr., M.D.

Kevorkian, Jack, M.D., THE STORY OF DISSECTION, Philosophical Library, Inc., New York, N. Y., 1959, 80 pp., \$3.75.

THIS BOOK IS A storehouse of information. However, the information is not presented as, "dry chronological data," but the author with his wonderful writing relates periods, investigators, and their work in a magnificent historico-philosophical network. It is a small book which has only ten short chapters.

In the first three chapters the author presents all the available information in the field of Anatomy. The Homeric Period, Classical Greece, and the Hellenistic Alexandria (Egypt), and the men who played a great role in the genesis of the new science of anatomy are discussed. Evidence is presented that Alexandria, under the influence of Aristotelian Hellenism, marked the first golden age for human dissection.

In chapters four (Rome) and five (Byzantium) progress is slower, but still anatomy follows the trend of reason.

In chapter six (Middle Ages) we see the period of the founding of the universities of Padua and Naples.

The state obligates every physician for the first time to learn anatomy.

In chapters seven (Renaissance), eight (Baroque Period), and nine (19th Century) the author presents a magnificent parade of glorious names such as: Pare, "Da Vinci, Michelangelo, Fallopius, Eustachius, Vesalius, Benivieni, Fernel, Harvey, Willis, Sylvius, Bartholin, Malpighi, Boerhaave, Valsalva, the brilliant Morgagni, Hunter, Rokitsansky, Virchow, etc., names which are considered to be, "The Fathers of Anatomy and Pathology."

The author arrives in the 20th Century (Chapter 10) not to close "The Story of Dissection," but to state that, "The story does not end here, for mortal man never reaches perfection."

A very enjoyable book to read.

John E. Skandalakis, M.D.

Guttmacher, Alan F., M.D., BABIES BY CHOICE OR BY CHANCE, Doubleday & Co., Inc., New York, N. Y., 1959, 289 pp., \$3.95.

THIS 289 PAGE BOOK is concerned with an exceedingly timely and controversial subject. It is written for the lay public by an obstetrician-gynecologist and discusses the control of conception, both positive and negative. The positive aspects include the treatment of infertility and of artificial insemination, while the negative involve contraception, sterilization, and abortion. This book is needed and should be widely read for several reasons.

First, there is a great deal of concern and interest in the so-called population explosion throughout the world. Dr. Guttmacher discusses in detail the three ways to control this problem: contraception, sterilization, and abortion. He, also, describes the various methods of contraception and rates them as to efficiency and acceptability. The goal and present status of contraceptive research is discussed. Secondly, the control of conception is deeply involved with ethical, religious, and political issues and, as a result, is one of the most confused and least understood aspects of American medicine. The stand taken by the different churches and the legal confusion that exists are clearly pointed out. The author, also, discusses the still very controversial subject of artificial insemination.

Dr. Guttmacher is eminently qualified to write on this problem. He has been one of the medical pioneers and leaders in trying to bring order and clarity to the subject. The book can be recommended to both physicians and the lay public who are interested in this pertinent problem.

Mark Pentecost, Jr., M.D.

Vignec, Alfred J., M.D., THE EMERGENCY SYNDROMES IN PEDIATRIC PRACTICE, Landsberger Medical Books, Inc., New York, N. Y., 1959, 382 pp., \$9.50.

A NEW YORK PEDIATRICIAN, Dr. Alfred J. Vignec, has compiled a fairly small book covering the problems in infants and children that require immediate attention. The author, who is Clinical Professor of Pediatrics at New York University, Pediatrician in Chief at New York Foundling Hospital and Director of the Pediatric Division at St. Vincent's Hospital has limited his volume to conditions which will not brook delay in management, the disease syndromes which confront every pedia-

PHYSICIAN'S BOOKSHELF / Continued

trician, and are of a nature that require rapid treatment while still in many cases diagnostic measures are being carried out.

The book is a practical one, covering the detailed management of cardiac failure in newborns, as well as older children, respiratory distress in all ages and from various causes, and the handling of all the common and uncommon congenital defects such as imperforate anus, tracheo-esophageal fistula and diaphragmatic hernia. A small section touches on meconium ileus and its relationship to generalized mucoviscidosis.

The chapter on the gastrointestinal tract covers fully the differential diagnosis of abdominal masses, though pointing out that they are relatively rare and (excluding the liver and spleen) mostly renal or perirenal. Dr. Vignec goes into detail on the medical conditions which may simulate surgical abdomens, and cause unnecessary abdominal explorations unless accurately diagnosed early in the course of the condition.

The section on poisons is adequate and the author calls for the establishment of more poison control centers across the country. Our small start on one such central information point in the emergency room at Grady Hospital is a step in the right direction, and surely should be expanded.

Metabolic disorders, central nervous system conditions, and hematopoietic diseases are covered well in this little book which is one worth reviewing by every pediatrician, as well as worthwhile keeping handy for quick reference in a tight situation which might demand immediate action.

Olin Shivers, M.D.

Ochsner, Alton, M.D., F.A.C.S., and DeBakey, Michael E., M.D., F.A.C.S. **CHRISTOPHER'S MINOR SURGERY**, W. B. Saunders Co., 1959, 539 pp., \$10.50.

THIS BOOK, AS DR. DEBAKEY and Dr. Ochsner so rightly emphasize, should not be considered as dealing with "Minor Surgery" because they feel this is a poor designation, because no surgery is "minor," at least as far as the patient is concerned. However, it does cover in a very noble fashion those conditions which can and should be diagnosed and treated in the physician's office, or in an out patient department of a hospital. The busy practitioner, the house officer on an out patient service and the medical student need, for quick reference, a text such as this concerning diagnosis and treatment of surgical disorders that do not require hospitalization. This book is filled with countless examples of such situations and the legends and descriptions depicting these particular situations are excellent.

In this present edition most chapters have been revised extensively. In the chapter on Arterial Disease, arteriosclerosis, which is such a common condition, is discussed fully. There are three completely new chapters involving Injuries of the Hand, Diseases of the Breast, and Physical Treatment in Minor disease.

The rudiments of surgery are very well described by Dr. Oscar Creech, Jr. and these include the equipment, surgical considerations and dressing and bandages. There is an excellent chapter on Anesthesia and Resuscitation written by Dr. John Adriani with a very good chapter on Infections written by Dr. Champ Lyons. All in all there are some 25 chapters very ably condensed into 517 pages which should be on the bookshelves of any doctor doing surgery in his office and certainly in all hospital out patient libraries where there is such a constant demand for this type of knowledge. It should prove an excellent reference source for much needed information which is afforded into a succinct and clear fashion.

Robert H. Vaughan, M.D.

M. A. G.—R. S. V. P.

GENTLEMEN:

We of the Hawaii Medical Association take much pleasure in extending a cordial invitation to your members to attend our 104th Annual Meeting to be held in Honolulu May 12, 13, 14, and 15, 1960.

King Kamehameha IV granted our charter on July 19, 1856, and the doctors of Hawaii have continued to meet through four successive types of government. The monarchy was overthrown in 1893 and the following year a president was named to head the new Republic. In 1898 Hawaii was annexed by the United States and Sanford Ballard Dole, the Republic's only president, became the

first appointed governor of the Territory of Hawaii. Today under statehood we have chosen by popular vote our first elected governor, William F. Quinn, whose office is in the Iolani Palace which was built in 1882 by King Kalakaua.

Since our 104th Annual Meeting will be the first under statehood, we are planning an exceptional program of scientific and social events, and we hope your members will be able to attend and help us celebrate this occasion.

Yours very truly,
Toru Nishigaya, M.D.
President

PRESIDENT'S FINAL LETTER

Dear Colleagues:

This is my last official President's Letter for the *Journal of the Medical Association of Georgia*. This fact, combined with other indisputable evidence, apprises me forcibly that my term of office is rapidly drawing to an end. One more somewhat convulsive effort should see me past my duties at the Annual Meeting. Thereafter, I will have firmly and gratefully in my grasp the welcomed and honored title of "Past President of the Medical Association of Georgia,"—while attempting to reassemble the shards of my medical practice.

The above anemic attempt at jocularity must not delude one into concluding that I have any remorse or regrets concerning the past year's activities. On the contrary, I have enjoyed it thoroughly. I freely acknowledge my appreciation of and obligation to the Muscogee County Medical Society and to the entire membership of the Medical Association of Georgia for permitting me to undergo these experiences!

And now a few random and unrelated observations of a valedictory nature:

First, my esteem and regard for the members of the medical profession has increased materially during the past year. Almost invariably, whenever a job needed doing, and there were many such instances, a simple request to one of our members resulted in the job being done effectively and enthusiastically. I have found the cooperation, talents, and energies among our colleagues are positively astounding!

Secondly, I can assure the membership of the Medical Association of Georgia that they have chosen their officers and councillors wisely and well. Mature deliberations and judicious decisions have characterized the work of these selfless individuals throughout the year!

Thirdly, I can state without qualification that the performance of our office personnel, particularly that of our Executive Secretary and of our Associate Executive Secretary, whose work I know best, has been outstanding. The Medical Association of Georgia is fortunate in having such personnel.

And lastly, after having observed closely the influence of organized medicine at the county, at the state, and at the national levels, it is my considered



Luther H. Wolff

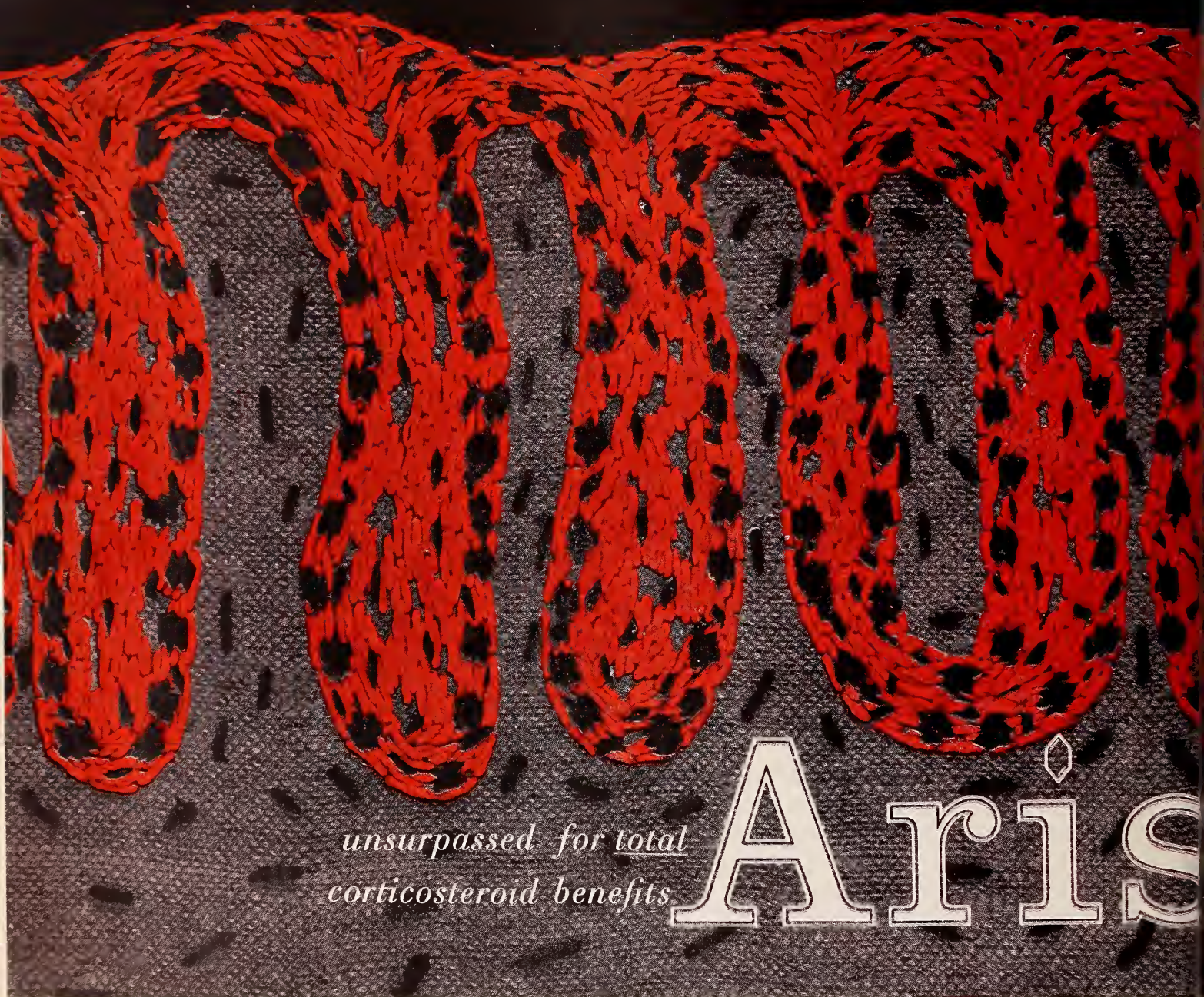
opinion that the future of American medicine depends directly on the strength and impact of these organizations. The pressures to change and modify the structure of medical practice is cumulative and vast, and will continue so. Only by a firm and united front, with concerted and unified efforts, can we hope to maintain that freedom of action so essential to top-quality medical care!

Again, let me express my gratitude for your support and help. Best wishes to Milford Hatcher and the Medical Association of Georgia for the coming year.

Cordially yours,
Luther H. Wolff, M.D.
President

P. S.: See you in Columbus May 1st!

in allergic and inflammatory skin disorders (including psoriasis)

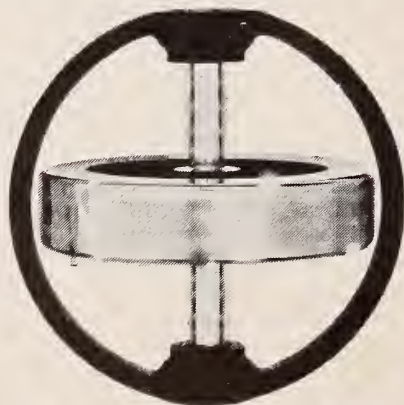


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- no voracious appetite — no excessive weight gain
- low incidence of peptic ulcer
- low incidence of osteoporosis with compression fracture

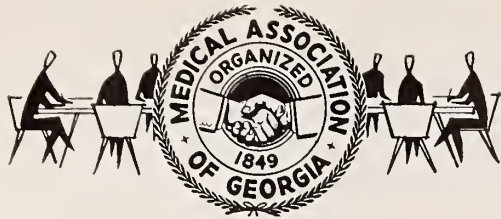
Precautions: With ARISTOCORT all traditional precautions to corticosteroid therapy should be observed. Dosage should always be carefully adjusted to the smallest amount which will suppress symptoms.

After patients have been on steroids for prolonged periods, discontinuance must be carried out gradually over a period of as much as several weeks.

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Diacetate Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

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the association

DEATHS

PEYTON ELLIOTT BELL, of Sylvester, died at the age of 91 on February 11.

Dr. Bell was born and reared in Webster County. He attended the Southwestern Agriculture College and in 1899 he graduated from the Georgia University School of Medicine.

As a young man, Dr. Bell taught school in Webster County. He moved to Sylvester in 1900 and began the practice of medicine and later opened one of the first drug stores in that city.

Survivors include two brothers, Judge R. C. Bell, Thomasville, and Homer F. Bell, Doerun, and several nieces and nephews.

ALBERT F. BRAWNER, 67, prominent Georgia psychiatrist, associated with the Brawner Sanitarium in Smyrna for 40 years, died February 27 in Marietta after a short illness.

Born in Chipley, Dr. Brawner came to Atlanta after finishing high school. He was graduated from Atlanta Medical College, now Emory Medical School, in 1915. He served overseas in World War I as a First Lieutenant in the Army Medical Corps.

Dr. Brawner attended the First Methodist Church in Smyrna and was a member of the Fulton County Medical Society, the Medical Association of Georgia, Southern Medical Association, the American Medical Association, Southern and Georgia Psychiatric Associations, and the Atlanta Society of Neurology and Psychiatry. He was also a member of the Smyrna American Legion Post.

Survivors include his wife; two daughters, Mrs. Albert Rambo, Marietta, and Mrs. George Matthews, Jr., Birmingham, Ala.; and five grandchildren.

PAUL HENRY DIETRICH of Chattanooga, Tenn., died February 29 at the age of 71.

Dr. Dietrich went to Chattanooga 24 years ago as roentgenologist and pathologist of Baroness Erlanger and T. C. Thompson Children's hospitals.

In addition to his career in Chattanooga, Dr. Dietrich organized the medical departments for General Motors plants in Pontiac, Michigan, and served as industrial surgeon for those plants for several years. He resigned to become superintendent of the George W. Hubbard Hospital and professor of physical and differential diag-

nosis at Meharry Medical College in Nashville.

He received his education at Keystone State Normal School (now Kutztown State Teachers College) and at the University of Pennsylvania School of Medicine.

During World War II, Dr. Dietrich did diagnostic roentgenological work for the Hamilton County Public Health Department and Pine Breeze as well as Erlanger and Children's hospitals.

Dr. Dietrich was a member of the American Medical Association, a Fellow of the American College of Physicians, a member of the staffs of Hutchinson Memorial, Erlanger, Memorial hospitals, and Pine Breeze Sanatorium, and a member of the Tennessee Medical Association, the Chattanooga-Hamilton County Medical Society, Tennessee Roentgen Society, Medical Association of Georgia, Tri-County Medical Association, Southern Medical Association, Roentgenological Society of North America, and the American Public Health Association. He was also a member of the Lutheran Church.

He is survived by three daughters, Mrs. Albert S. Easley, Chattanooga, Mrs. Robert D. MacCurdy, Logan, Utah, and Mrs. Warren P. Willman, Chicago; two sons, Paul W. Dietrich, Dallas and Donald G. Dietrich Chattanooga; and nine grandchildren.

PAUL S. KEMP, 57, of Macon, died February 23 in an Atlanta hospital.

Dr. Kemp was a graduate of the Medical College of Georgia in Augusta, and had practiced in Virginia before returning to practice in Georgia in 1936.

He was a member of the Vineville Methodist Church at Macon and Alpha Omega Alpha honorary medical fraternity and Theta Kappa Psi social fraternity.

Survivors include his wife; two daughters, Miss Katherine and Miss Elizabeth Kemp, both of Macon; three sisters, Mrs. C. A. Joiner and Mrs. D. D. Joiner, both of Atlanta, and Mrs. F. T. Tiller, Woodville, and a brother, William I. Kemp, Shreveport, La.

ALBERT O. LINCH, 59, former president of the Fulton County Medical Society, died February 26 in a private hospital in Atlanta.

Dr. Linch was graduated in 1925 from the Emory University School of Medicine and had been in private practice here since 1927.

He was a member of the American College of Surgeons, the American Medical Association, Medical Association of Georgia, Fifth District Medical Society, Phi Beta Pi medical fraternity, Yaarab Temple of the

Shrine, Atlanta Athletic Club, and was a Fellow of the Southeastern Surgical Congress.

Dr. Linch was a faculty member at Emory University School of Medicine and was a steward at Druid Hills Methodist Church.

Survivors include his wife; a daughter, Mrs. W. D. Jordan, Atlanta; two sister, Mrs. B. F. Stovall, Atlanta and Miss Eugenia Linch, Winston-Salem, N. C.; four brothers, Howard L. Linch, Atlanta; W. E. Linch, Rome, Frank Linch, McDonough, and Samuel H. Linch of Silver Springs, Md.

H. M. McKEMIE, of Albany, died at the age of 55 in Atlanta on March 5.

Born in Randolph County, Dr. McKemie attended the University of Georgia and received his M. D. degree from the Medical College of Georgia.

After serving his residency, he established his practice in Albany in 1932, and had resided there since that time, except for the time spent in the Air Force during World War II. He held the rank of Major at the war's end.

Active on the staff of Phoebe Putney Memorial Hospital throughout his career, Dr. McKemie was a former president of the Dougherty County Medical Society.

In addition to being a senior Fellow in the American College of Surgeons, Dr. McKemie was a senior Fellow in the Southeastern Surgical Congress, and a member of the Association of Military Surgeons.

He was an active member of the First Methodist Church in Albany, where he was a former steward.

Survivors include his wife; two daughters, Mrs. Richard Dozier, Sarasota, Fla. and Mrs. Lamar Reese, Albany; three brothers, Dr. C. R. McKemie, Albany, State Rep. Henry G. McKemie, Coleman, and W. J. McKemie of Clay County; two sisters, Mrs. J. T. Hammock of Clay County and Miss Martha McKemie, Atlanta; and two grandchildren.

BOMAR A. OLDS of College Park died February 26, having practiced medicine in College Park for some 40 years.

Dr. Olds was a graduate of Georgia Military Academy and Mercer University. He received his M.A. and M.D. degrees from Emory University, where he was a member of Sigma Alpha Epsilon and Alpha Kappa Kappa fraternities.

Dr. Olds was a member of the Atlanta Kiwanis Club, the Fulton County Medical Society, the Medical Association of Georgia, the Southern Medical Association, the Ear, Eye, Nose, and Throat Society of Atlanta, and was a life member of the American Medical Association.

He was a member of St. John's Episcopal Church in College Park, and was a Mason, a Shriner, and a member of the Civitan International.

Besides his wife, he is survived by two sons, Dr. Robert F. Olds, Atlanta and Bomar A. Olds, Jr., Cornelia; two daughters, Sister Gabriella Marie, Phoenix, Ariz. and Mrs. A. M. Fausel, Smyrna; two sisters, Miss Eloise Olds, College Park and Mrs. Hubert L. Jacobs, Jacksonville; Fla.; and seven grandchildren.

CYRUS K. SHARP, of Arlington, died March 12 at the age of 92 at his home.

Dr. Sharp, who was voted "Georgia General Practitioner of the Year" in 1952 by the members of the Medical Association of Georgia, was a former past president of that organization. He was a delegate to the American Medical Association for four years and served for 30 years on the Georgia Board of Health.

He is survived by his wife, the former Mary Elizabeth Brown and two sons.

D. C. SIRMONS of Dahlonega, died at the age of 44 December 5 following several years of poor health.

A native of Cook County, he had lived in Dahlonega since 1933. He was the son of the late J. C. Sirmons, Dean of North Georgia College for many years, and Mrs. Sirmons, a member of the North Georgia College faculty.

Dr. Sirmons attended Emory University and the Medical College of Georgia where he was a member of the Phi Chi medical fraternity and Alpha Omega Alpha honorary fraternity.

He practiced medicine in Dahlonega for 10 years and was North Georgia College physician for six years. He served in the armed services as a Captain during World War II.

Survivors include his wife; four children, John, Toby, Robin, and Paula, all of Dalton, and his mother, Mrs. J. C. Sirmons of Dahlonega.

CLINTON MONROE TEMPLETON, 46, of Augusta, died suddenly February 28 while aboard his cabin cruiser on Clark Hill Reservoir.

Dr. Templeton received his M.D. degree from the Medical College of Georgia.

He was a past president of the Richmond County Medical Society and a member of Arcadia Lodge No. 115 F. & A.M. He was a Lt. Col. in the U. S. Army Medical Corps during World War II.

Survivors besides his wife, Mrs. Lurline Eubanks Templeton, include one son, C. M. Templeton, Jr., and one daughter, Miss Martha Faye Templeton, both of North Augusta; three brothers, William A. Templeton, Augusta, C. H. Templeton, North Augusta, and F. H. Templeton, Blythe; five sisters, Miss Anna Templeton and Mrs. S. J. Waters, both of Sylvania, Mrs. P. A. Shuman, Montgomery, Ala., Mrs. L. B. Timmerman, Americus, and Mrs. J. B. Cook, Valdosta; and several nieces and nephews.

PERSONALS

First District

GEORGE W. STRAIGHT, Savannah, was recently elected commander of the Savannah Chapter, Military Order of World Wars.

FRANK T. ROBBINS, Vidalia, has formally tendered his resignation as Institutional Surgeon for the Georgia State Prison System.

Second District

The last 10 years of progress in the work of the Georgia Heart Association, a unit of the National Heart Association, was explained by W. P. STONER of Sylvester, to the Sylvester Kiwanis Club recently.

Third District

ROBERT C. PENDERGRASS, of Americus, was recently elected vice-president of the American College of Radiology at the annual meeting held in New Orleans, La.

Fourth District

No news submitted.

Fifth District

R. BRUCE LOGUE, of Atlanta, recently addressed the Richmond Area Heart Association in Richmond, Va. Dr. Logue also addressed the Hillsborough County Heart Association in Tampa, Fla. recently.

DR. and MRS. MURDOCK EQUEN, of Atlanta, recently attended the meetings of the American Laryngological Association and the American Broncho-Esophagological Association held in Miami Beach, Fla.

Sixth District

"Preventing Accidents in Older People" was the subject of a talk which WALTER P. BARNES, JR., of Macon, gave at the annual open meeting of the Bibb County Medical Auxiliary recently.

Seventh District

No news submitted.

Eighth District

W. B. BATES, JR., Waycross, recently spoke to a meeting of the Business and Professional Women's Club in Waycross on "Psychosomatic Medicine."

Ninth District

JANET KING JOHNSON has opened her office in Gainesville for the practice of pediatrics.

Tenth District

At a recent meeting of the Augusta Life Underwriters Association, HARRY T. HARPER, JR., Augusta, spoke on "Heart Disease and the Care of the Heart."

SOCIETIES

The Fourth Annual Southwest Georgia Medical Seminar, featuring a number of distinguished physicians, was held at the Albany Elks Home recently. A number of papers were presented by members of the DOUGHERTY COUNTY MEDICAL SOCIETY.

J. Everett Barfield, Vidalia, has been elected president of the SOUTHWEST GEORGIA MEDICAL SOCIETY. Frank T. Robbins, also of Vidalia, was named secretary-treasurer.

WILLIAM JACKSON HUTCHINS

THE CHATTAHOOCHEE MEDICAL SOCIETY, composed of the physicians of Forsyth and Gwinnett counties, calls attention to the recent loss of our beloved member, Dr. William Jackson Hutchins. A native of Barrow County, Georgia, son of John Hutchins and Margaret Wages Hutchins, Dr. Hutchins graduated from the Atlanta College of Physicians and Surgeons (now Emory University School of Medicine) in 1910. He moved to Buford in 1912, and was a very active physician in that city and Gwinnett County for 46 years. Dr. Hutchins was a member of the Buford Methodist Church, a Mason, a member of the American Medical Association, the Medical Association of Georgia, Ninth District Medical Society, and Chattahoochee Medical Society. In 1948 the Hutchins Memorial Hospital at Buford was completed, due largely to the efforts and interest of Dr. Hutchins, and the hospital remains as a memorial to him.

During his life Dr. Hutchins delivered more than 6,000 babies and, as a general practitioner of outstanding ability, endeared himself to many thousands of people. During his entire career Dr. Hutchins held the affection and highest esteem of his fellow physicians, being always kind and courteous in every professional

and social contact.

Dr. Hutchins will be long remembered by the people of our section for his ability, untiring devotion to duty, and willingness to serve those who asked for his assistance, regardless of their ability to pay for his services.

Therefore, be it resolved that the Chattahoochee Medical Society and our counties have lost one of our most outstanding members, a valuable citizen, and a Christian gentleman whose unselfish efforts helped place the medical profession in high esteem among the people whom it serves.

Be it further resolved that a copy of this resolution be published in the Buford Advertiser (Buford), News Herald (Lawrenceville) and Forsyth County News (Cumming), a copy be spread upon the permanent minutes of the Chattahoochee Medical Society, and a copy be sent to the family of Dr. Hutchins.

Respectfully submitted,

Rupert H. Bramblett, M.D.
Fayette Sims, M.D.
Cecil Miller, M.D.



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Photograph illustrating surgical infections by Ted F. Leigh, M.D., Atlanta.

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HYPNOSIS IN PSYCHIATRIC PRACTICE

An outline is presented of the values and uses of hypnosis, together with some of its limitations.

Harry R. Lipton, M.D., *Atlanta*

I HAVE BEEN USING hypnosis in psychiatric practice for the past 23 years. As the result of considerable publicity in relation to the use of hypnosis in the local press, nationally, and internationally, I am in receipt of frequent requests for hypnotic therapy. I consider hypnosis a tool and not a treatment and my practice is to select cases for hypnotherapy carefully. For many years I have not agreed to give hypnotic therapy on request of the patient. My practice is to examine the patient carefully, arrive at a diagnosis, and decide myself what type of treatment is indicated in the particular case.

My experience has been that the majority of those most anxious to receive hypnotic treatment should not have this form of treatment. I have found many such patients to be suffering from psychoses, other severe mental illnesses, and personality disorders and in need of some other form of treatment. Quite a few patients who have requested hypnotic treatment from me I have found to be actively deluded and hallucinating. Delusions of hypnotic influence, or being under some spell, are the most common type of delusions seen in the schizophrenic psychoses, particularly in this part of the country. Such individuals are of the conviction that only some form of hypnosis or magic will relieve them of their symptoms. They expect results and, if a particular treatment is agreed upon and the desired results not achieved, they commonly become hostile and paranoid.

Hypnosis as a tool has three uses: (1) diagnosis, (2) the recovery of forgotten and unconscious material, and (3) the removal of symptoms.

The loss of a function, as commonly occurs in hysterical disorders, is merely an indication of some

deep-lying psychiatric disorder, as headache may be a symptom of brain tumor. I recall treating a patient with hysterical deafness at a city hospital 17 years ago, before the interns and resident staff. The patient was easily hypnotized and her hearing restored to the great satisfaction of all. The following day this physician saw the resident in the hallway; he advised him that this patient was still hearing well, but had lost her voice. This symptom, too, responded dramatically to hypnotherapy and the function remained intact. However, on the following day the patient suffered loss of vision. She was transferred to a mental hospital for treatment for her psychosis.

Before removing a hysterical symptom the physician should understand fully the origin of the symptom and its purpose in the patient's life and functioning. Removal of the symptom without attention to the underlying conflicts and psychopathology results in either overwhelming anxiety or acute depression. All individuals tend to forget what is unpleasant and painful to remember. Such experiences have been of an antisocial nature, or are so emotionally laden that they are too difficult to cope with on a conscious level. All cases of psychological amnesia respond dramatically to hypnotherapy and are of profound public interest, usually appearing on the front pages of newspapers. One cannot stop, however, with the treatment of the amnesia. This commonly conceals plans to commit acts of violence or overwhelming homicidal or suicidal preoccupations and compulsions. In such cases the amnesia helps protect the individual from committing a kidnapping or hold-up, or from killing himself or another person and suffering the consequences thereof.

Hypnosis is an exceedingly valuable tool in diagnosis, particularly in individuals charged with crimes. It is a violation of the individual's civil rights to use

Presented before the Georgia Society of Clinical Hypnosis, January 9, 1960.

hypnosis to obtain a confession of a crime from him. It can, however, be used to aid in establishing a diagnosis and this is frequently done. There are, indeed, borderline cases where it would be difficult to use hypnosis in establishing a diagnosis without bringing to light information which would be most detrimental to the patient's freedom and result in criminal proceedings against him. The psychiatrist must use his own discretion and judgment in using hypnosis in criminal cases. Below is an excerpt from a recent interesting medico-legal case in which hypnosis was used as a diagnostic tool.

Case History

Subject is a large, well-developed, muscular, 34 year old, white male. He has a dreamy facial expression and is poorly attentive during examination. He does not speak spontaneously. He states his name is X—; he answers, "I don't know," to all questions.

Under light hypnosis he speaks freely and spontaneously. He relates he was born and raised in X—, Arkansas. He is the fourth of nine siblings. He finished the seventh grade in school at 14 years of age, then went to work. He married at 18 years of age; he and his wife divorced when he was 27. They have two children, ages 16 and 12. He relates he was in the U.S. Navy from July, 1942 to October, 1943. He was hospitalized for two weeks for appendectomy. His memory for the ensuing three months is not clear. He was transferred to a U.S. Naval Hospital where he remained under treatment for three months, following which he was discharged from Service. Since discharge from Service he has drunk periodically to excess.

He relates he served 20 months at the penitentiary at X— on a bad check charge. He states that actually his wife signed his name to some checks; he did not want her to suffer and kept quiet about this. He states that at the time the checks were written he and his wife were already divorced. He was discharged from the penitentiary in August, 1954. After getting out of prison he returned to X— where he worked in garages and cotton mills, except for a period of time when he worked for a car dealer in Tennessee. He returned home in 1958 when his father died.

Regarding his present difficulty he states that in July of this year he purchased a 1957 Ford from a Mr. A in X— City, Florida for \$600. One week later he traded the Ford off to a Mr. B. at an auto sales in X—, Georgia for a pick-up truck and a 1952 Buick. He states the motor was bad in the pick-up truck and he sold it for \$217.50. He gave the money to a friend to deposit in the bank for him. He had a bad headache and was going to see a doctor. The doctor he wanted to see was not in, so

he started for another town to see a doctor there. He was stopped by the State Patrol, who told him there were some traffic charges against the car. He states that Mr. B. of the auto sales company came to the jail to see him and he gave him a deed to the Buick. Mr. B. told him he had to give up the Ford, as it was a stolen car; he did not want Mr. B. to lose anything.

After awakening from the hypnotic state, subject inquired as to whether his brother was in the next room waiting for him, and stated he might as well go on home. He professed to be unaware of his surroundings and inquired as to what day it was. He again professed to have no recollection of being in any trouble of any kind and answered, "I don't know," to most questions.

This examiner was at that time unable to determine whether subject was malingering or suffering from a psychosis. It was recommended he be returned for re-examination.

Subject was re-examined after a lapse of five weeks. He had a sad, dreamy facial expression and was slow and retarded in speech and movement. He apparently did not recognize this physician and did not remember being in the office before. He stated his name was X—. To all other questions he replied, "I don't know." He showed this physician his wallet and social security card. He stated he was living in a jail; he did not know how long he had been there, or where he was.

In the hypnotic state he spoke at length about his past life, of how he had gotten into trouble in the State of X— and served time in prison there. He stated that he had been troubled with awful headaches since a big blast in 1943 while on duty in the U.S. Navy. He stated he was master of some guns that blew up an enemy submarine at close range. After the explosion he kept fouling-up orders; he came to several months later in a naval hospital. He related he had worked in Tennessee for a brother-in-law, who owned a Buick Agency. He then moved to X— early in 1958 and remained there until his father died a year ago. He then went to work in a mill at X—, Arkansas.

Regarding his present difficulty, he stated he awoke one day in a motel in Florida. A Mr. A. had sold him a 1957 Ford for \$600. He recalled he had \$637 in his wallet; he was not sure where he got the money. He stated he traded this car to a Mr. B for a 1952 Buick and a pick-up truck. He was picked up by the State Patrol on his way to see a doctor, taken to jail, and locked up. Three days later he was transferred to Atlanta.

He spoke at length about his nervous condition. He stated he frequently blanked and did not know where he was. One night he came to in X—, fixing

HYPNOSIS / Lipton

to go into the State of X—; he had blacked out on his way home. He complained repeatedly of headaches. He stated that a lot of people worried him; he wished people would just leave him alone. He was frequently afraid he was going to hurt someone. He alleged doctors in the Navy wanted to operate on his head and told him he did not have long to live. They allegedly told him he had "something loose" in his head. He stated that since being in jail someone had written him a letter, saying he was his brother and was coming to see him; he could not recall having a brother. Upon awakening from the hypnotic state patient was again disoriented as to time, place, and person. He complained of headache and believed he might be in some kind of trouble over a car.

Subject is of a poorly integrated personality type; there is a history of maladjustment dating back to youth. The records indicate that he suffered from neurotic and hysterical symptoms while in Service, for which he was hospitalized and treated. He was discharged from Service with a diagnosis of: psycho-neurosis, hysteria. Records also indicate that upon examination at a penitentiary in 1954 he exhibited hysterical symptoms in the nature of amnesia of repeated offenses he had committed. The history and records indicated that subject had been mentally ill for some time.

As the result of the examinations this physician was of the opinion that subject was suffering from a hysterical psychosis and lacked the capacity to advise with his counsel and assist properly in his defense. It is probable that his psychosis was precipitated by his arrest and detention in jail. Under situations of stress his subconscious mind came to his rescue, with resulting dissociated states and loss of memory for things he had done and antisocial acts he had committed. This served to lighten his emotional burden. It was recommended that he be committed to the appropriate state mental hospital. The prognosis as to recovery from his psychosis was considered to be good with treatment in a hospital setting.

This physician has used hypnosis in the control of excessive smoking and in the treatment of alcoholism. Each alcoholic must be individually and carefully examined before the type of treatment best suited to

his case can be determined. Alcoholics with much underlying psychopathology are poor candidates for hypnotic therapy. Drinking and smoking, even in fairly well adjusted individuals, cannot be treated successfully by hypnotherapy unless the therapist understands the origin of this habit and is in a position to help the individual find and achieve substitute emotional satisfactions for it.

Migraine, stuttering, psychosexual impotence, frigidity, and certain neurological conditions respond well to hypnotic treatment. The use of hypnosis is frequently the treatment of choice and, on occasions, the only tool suitable. A deep knowledge of psychodynamics and psychopathology is necessary in the treatment of these conditions. Schizoid personalities, mental defectives, and severe psychoneurotics with depression, should not be treated with hypnosis. The patient should understand the nature and purpose of the treatment. Narcohypnosis, the induction of the hypnotic state with the aid of one of the barbiturates, such as sodium pentothal, has been found most helpful in inducing the desired twilight state in many of these patients. One should be familiar with the contraindications to the use of these drugs.

Hypnosis has been found valuable in helping individuals relive forgotten traumatic experiences and dissipate the intense emotions connected with the forgotten experience. This is of great value in both civilian and military practice.

Acute and chronic neurological disorders have been treated successfully by narcohypnosis, with dramatic results. These include anesthetics, paralyses, and contractures of considerable standing. Hysterical spasms of extremities and hysterical motor neuroses of a disabling and incapacitating nature commonly respond dramatically to hypnotherapy. The results achieved are probably as dramatic as those which occur at the Shrine at Lourdes.

In neurological disabilities where the case is in litigation, I usually defer narcohypnotic therapy until all financial aspects of the case have been completely settled. It has been my common observation that any improvement obtained while the case is still pending in the courts is short-lived. Few individuals desire to recover from a loss of function, either consciously or subconsciously, for which they are likely to be well compensated.

490 Peachtree St., N.E., Suite 243

Annual Session of the Medical Association of Georgia

May 7-10, 1961

Atlanta, Georgia

A GIFT OF GRATITUDE

ON APRIL 7, 1960, Dr. Luther H. Wolff, President of the Medical Association of Georgia joined the members of the Fulton County Medical Society at their regular monthly meeting held at the Academy of Medicine on West Peachtree Street to present a gift of appreciation from the Medical Association to the Fulton County Society.

Two decades ago the members of the Fulton County Society were generous enough to let the members of the Medical Association use part of their building for their headquarters offices. Since that time both organizations have grown in size tremendously. More space was needed by both, so the Medical Association began looking for new quarters.

The Medical Association found such quarters and moved from the Academy of Medicine in February, 1960.

Parting as the best of friends, the Medical Association felt the need to show its appreciation to the Fulton County Society by giving a gift of need as well as a gift of gratitude.

After investigating the needs of the Fulton County Society, it was decided to give them a leather president's chair. Although, it is a handsome chair, it is only a small token of thanks for all that this Society has done for the Medical Association. In presenting this chair, Dr. Wolff read the following resolution:

WHEREAS, the Fulton County Medical Society has provided office space and facilities for the Medical Association of Georgia for two decades in the Academy of Medicine, 875 West Peachtree Street, N.E., Atlanta; and

WHEREAS, the Fulton County Medical Society also made available to the Medical Association of Georgia additional office space and facilities when such was sought for meetings and the conduct of the business of the Association; and

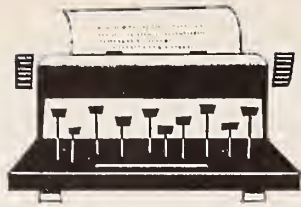
WHEREAS, this arrangement was always most cordial and hospitable and proved of untold value to the Association during the many years of this close relationship; and

WHEREAS, The Medical Association of Georgia, having now established its own Headquarters Office Building, has removed its offices from the Academy of Medicine,

NOW THEREFORE BE IT RESOLVED, that the Council of the Medical Association of Georgia in behalf of its 70 component county medical societies and its 2,900 members wishes to express its sincere gratitude and appreciation for this service and cooperation; and

THEREFORE BE IT FURTHER RESOLVED, that the Medical Association of Georgia hereby presents to the Fulton County Medical Society with a small token of remembrance to honor and mark this contribution made by the Fulton County Medical Society to further the interests of the profession in Georgia.

Again, the Medical Association of Georgia wishes to take this opportunity to thank the members of the Fulton County Medical Society for the immeasurable service it has rendered to the entire Association.



editorials

Fred Huie Simonton New President-Elect

FRED HUIE SIMONTON of Chickamauga was named president-elect of the Medical Association of Georgia for the year 1960-1961 at the 1960 Annual Session of the Medical Association of Georgia held in Columbus, May 1-4.

A general practitioner, born in Heard County, Georgia, Dr. Simonton attended the A. & M. School, Carrollton; the University of Georgia, Athens, and received his M.D. degree from the Medical College of Georgia at Augusta. He served his internship and residency at the Macon Hospital, in Macon.

Before going into private practice in Chickamauga in 1933, Dr. Simonton served as District Health Officer for Walker, Dade, and Catoosa counties. Dr. Simonton has been a very active member of the American Academy of General Practice, the Georgia Academy of General Practice, and the Medical Association of Georgia. He is past vice president of the American Academy of General Practice and was Georgia Delegate to the AAGP from 1948-1954, having been re-appointed this year. He has also served the AAGP by serving as a member of the Board of Directors and as a member of the Executive Committee. Dr. Simonton is past president of the Georgia Academy of General Practice and is vice speaker of the House of Delegates of the Medical Association of Georgia. He served as Georgia's delegate to the AMA in 1950-51 and has been a delegate to the Medical Association of Georgia since 1932, missing only one session.

Since 1950, Dr. Simonton has been a member of the State Board of Health, serving as chairman from 1957-1960. He is also special consultant to the Chronic Disease Program of the United States

Public Health Service, Department of Health, Education, and Welfare.

After having read the preceeding paragraphs, it



FRED HUIE SIMONTON
President-Elect 1960-61

seems that Dr. Simonton has certainly served his profession well, but he has even done much more. He is a member of the Chattanooga Area of General Practice, serving as a member of the Board of

Directors; Chairman of the Scientific Committee of the Medical Association of Georgia, and is also a member of the Board of Directors of the Georgia Academy of General Practice.

Although much of his time is spent with his profession, Dr. Simonton has still found time to serve his country and community in many other ways. He served as an Army Reserve Officer from 1929-1940, is a member of the Chickamauga Civic Club, Lafayette Georgia Lions Club, City Farmers Club of Chattanooga, Saddle and Cattle Club of Chattanooga, Crawfish Springs Lodge Number 300 F &

AM, American Aberdeen-Angus Breeders Association, Georgia Aberdeen-Angus Breeders Association, and the Georgia Egg Association.

Dr. Simonton is a member of the Official Board of the Elizabeth Lee Methodist Church in Chickamauga and served as chairman of their Special Gift Building Fund Committee.

The members of the Medical Association of Georgia are very proud of their selection of Fred Huie Simonton as their new president-elect and truly look forward to a most successful year under his leadership.

A. M. A. Annual Session in Miami

THE 109TH ANNUAL MEETING of the American Medical Association to be held in Miami Beach June 13 through June 17 represents the first time that such a meeting has been held in the southeast. An interim meeting was held in Miami Beach in the winter of 1954.

The scientific portion of the meeting will take place in the Fontainebleau Hotel and in the completely air-conditioned Miami Beach Auditorium located a short distance from ocean front hotels. We believe the location for this year's meeting is ideal for the doctor and his entire family, and from what has been seen of the scientific program being planned, it too offers a superior postgraduate opportunity for the physician. Approximately 2,000 physicians will participate in presenting the scientific portion of the meeting. In addition to the scientific papers, about 290 exhibits will be on display representing the best exhibits selected from 540 applications. An appropriate program of motion pictures and television which will be coordinated with the rest of the scientific program will be presented in the Miami Beach exhibition hall.

More than 2,000 physicians' wives will attend

Auxiliary meetings which are being held in conjunction with the American Medical Association annual meeting.

Even with so large a gathering as the A.M.A. meeting, Miami Beach should experience no real difficulty in accommodating our meeting. An estimated 125,000 visitors can be accommodated in Miami Beach at any given time. Including metropolitan Miami there are a total of 917 hotels and motels with 55,000 rooms.

Transportation to and from the convention city should likewise present no difficulty. Miami has one of the nation's busiest airport facilities so that air transportation should present no problem from any part of the country. Several crack streamline trains terminate in Miami. With the opening of the Sunshine Tollway down the East Coast of Florida to Miami, automobile transportation from this area to Miami should be much easier than in former years.

Since Miami Beach is widely known as one of the nation's most attractive playgrounds, this should prove a potent influence in luring many doctors and their families to the Annual Session next month. We hope to see you there.

The President's Chair

SINCE THE HEADQUARTERS OFFICE of the Medical Association of Georgia first occupied the basement

of the Academy of Medicine in Atlanta two decades ago, many changes have taken place. The one thing

that did not change through the years, however, was the continued warm relationship between landlord and tenant. The State association has always been grateful for the many kindnesses of the Fulton County Medical Society but these sentiments had never been formally expressed.

Since the recent move to the new headquarters office building on Peachtree Street, it was felt that some official recognition of the contribution made by the Fulton County Medical Society was in order.

At the regular monthly meeting of the County

Society on April 7, 1960, your President, Dr. Luther Wolff, made the formal presentation of a handsome President's chair to commemorate the long and cordial relationship between the two organizations. The chair was graciously accepted by Dr. J. D. Martin, President of the Fulton County Society.

This chair will symbolize for many years to come the close and harmonious relationship between a local group and parent organization which may be achieved in promoting the interests of the profession in Georgia.

MAG Insurance Progress

LAST MONTH A CONTRACT was signed between the Medical Association of Georgia and the Life Insurance Company of Georgia, to extend major hospitalization insurance to cover widows of doctors and their dependents. It has long been apparent, that organized medicine does not have as extensive or as complete group insurance coverage as is available in many industrial organizations. This step to extend catastrophic insurance to the widows and dependents of deceased doctors is a move in the direction of improving the general scope of coverage for organized medicine in Georgia.

It is hoped that in the future additional expansion of the general scope of insurance will be accomplished. Another plan which is under consideration at the present moment, is a comprehensive insurance program including hospitalization, medical benefits,

life insurance, and disability insurance for the employee's of doctors. It is increasingly difficult today to compete with industry for the employment of competent personnel. One of the drawbacks which a doctor has is his inability to furnish security in the form of comprehensive insurance. It is hoped that the proposed program of coverage for employees will be negotiated successfully in the not too distant future.

Another matter of interest to doctors of Georgia was the result of the recent negotiations between St. Paul Mercury Indemnity Companies and the Medical Defense Committee of the MAG. Significant reductions were obtained in the premiums to be paid for professional liability insurance. Your local agent will shortly have this information for your consideration.

ART EXHIBIT

THE 23RD ANNUAL EXHIBITION of art works by American physicians will be held June 13 through June 18, 1960, at the Miami Beach Exhibition Hall and Auditorium, it was announced today by Lewis M. Johnson, M.D., President of the American Physicians Art Association.

Held in conjunction with the annual convention of

the American Medical Association, the show will include over 300 works of art in oil, water color, sculpture, crafts, photography, and lithography.

Participants and prospective exhibitors may obtain further information from Dr. Kurt F. Falkson, 7 East 78th Street, New York City, Secretary of the American Physicians Art Association.



mental health page

PRE-MENSTRUAL TENSION

PREMENSTRUAL TENSION is today one of the most common of all the syndromes confronting the doctor dealing with women. Whether it is increasing actually or only apparently is rather hard to determine. This writer believes that partly it is another manifestation of the increased tension under which most people seem to live these days. Undoubtedly, however, it becomes apparently more frequent because we now recognize it as a definite syndrome which we should attempt to treat.

Ferguson and Hamilton¹ studied two groups of women in a hospital. The first group included white females working as nurses, technicians, secretaries, and social workers. The second group consisted of colored women working as nurses' aids, maids, housekeepers, waitresses, and kitchen help. In 92 per cent of the first group and 91 per cent of the second group they found definite premenstrual tension. Since the two groups are rather widely divergent in background, social environment, and education, they postulate that the incidence is probably the same in the general population.

The common manifestations of this syndrome are breast tenderness, headache, backache, pelvic pressure and discomfort, facial eruptions, mental depression, and irritability. These may be present in any combination and the duration may be anywhere from one and a half to 14 days. Usually there is rather dramatic relief with the onset of the menstrual flow.

Personal observation and close questioning reveals that the syndrome is more common and more pronounced after age 30, and may vary in intensity from one period to another. It has also been this

Albert J. Kelley, M.D., *Savannah*

writer's definite impression that in all cases the syndrome is worse during times of unusual stress and tension from any cause.

Treatment must vary with the individual. It has been postulated that there is fluid retention during the premenstrual phase with congestion and edema of the pelvic organs. For this reason various diuretics have been used with varying success. Progesterone, either orally or by injection, seems to benefit a few patients and the various ataraxic drugs and tranquilizers have been widely used. This author agrees with McGavack and his group in New York² that the most useful single drug is the theophylline-antihistamine preparation marketed under the name of Neo-bromth[®] in doses of 160 to 320 mg. per day. When used it will usually be found that often a patient will not find a need for the drug until two or three days before the onset of the flow, while at other times she will need to take it from 10 to 14 days.

Most of all these women need understanding of their problem. As in all cases, fear of possible surgery, fear of possible cancer, or even fear of the need of formal psychiatric therapy will magnify the symptoms out of all proportion or even prevent their seeking help.

A careful and complete pelvic examination to rule out pathology including a routine Pap smear plus explanation of the problem and reassurance go

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

MENTAL HEALTH PAGE / Continued

far to give relief. Many women have been seen actually frightened because some friend or relative or a harried doctor casually dismissed their symptoms as early menopause. A woman so frightened, and having this problem added to her other tensions, can actually be hastened toward a definite psychosis and the need for formal psychiatric care.

Here then, is an area in which practically all doctors can actively contribute to good mental health. By recognizing the importance and widespread incidence of this syndrome, by careful examination of his patients plus a careful history, by tak-

ing the time to explain matters and allay fears, he can greatly help many patients. By thus easing tensions of the patient herself, he also eases the tensions of her family and children. The resultant contribution to better mental health of the entire population can be tremendous.

The grateful response of only a few patients whose husbands find them "easier to live with" more than repays for the slight extra time taken with these patients.

References

1. Fergerson and Hamilton, Ob-Gyn 9:615-619, May, 1957.
2. McGavack, et al, A. J. 72:416-422, August, 1956.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Castellow, Wm. F.	Public Health Dept. Americus	Active	Sumter
Creagh, Gerard B.	175 Hill Street Athens	Active	Crawford W. Long
Gibbs, Sydney R.	Roberta	Active	Peach Belt
Johnson, Margaret W.	Vereen Mem. Hospital Moultrie	Active	Colquitt
Kemp, James A.	Medical College of Georgia Augusta	Active	Richmond
Lambert, Robert Y.	1208 W. Peachtree St., N.W. Atlanta 9	Active	Fulton
Morton, Wm. J.	1st Avenue, N.E. Cairo	Active	Grady
Shull, Vivion F.	109 W. Washington St. Summerville	Active	Chattooga
Sills, Carl E.	General Delivery Plains	Active	Sumter
Wilds, Preston L.	Medical College of Georgia Augusta	Active	Richmond
Womble, James G.	2373 Franklin St. Augusta	Active	Richmond
Woodward, Louie F.	Talmadge Memorial Hospital Augusta	Active	Richmond



legal page

MEDICAL SOCIETIES AND POLITICS NO. 2

John L. Moore, Jr., *Atlanta*

IN THE MARCH ISSUE of the *J.M.A.G.* we considered the restrictions on expenditures in support of or in opposition to candidates for Federal office. In this issue we shall briefly discuss restrictions on lobbying and the use of political action committees.

The political rights of physicians and their associations are very clear, as expressed in the First Amendment to the U.S. Constitution:

"Congress shall make no law . . . abridging the freedom . . . or the right of the people . . . to petition the Government for a redress of grievances."

However, the regulations of the rights of citizens, whether individual physicians or their professional societies, are strict and not necessarily what one might expect without being informed.

The Federal Regulation of Lobbying Act of 1946 (2 United States Code Annotated, Sections 261 through 270) applies to:

"... any person . . . who by himself, or through any agent or employee or other persons in any manner whatsoever, directly or indirectly, solicits, collects, or receives money or any other thing of value to be used principally to aid . . . to influence, directly or indirectly, the passage or defeat of any legislation by the Congress of the United States."

Any such "person" (including individuals, partnerships, corporations, associations, etc.) must register with the Clerk of the House of Representatives and file quarterly reports revealing his financial affairs with Congress.

Obviously, this provision normally only affects

physicians through the American Medical Association. The A.M.A. takes the position that it is not covered by the Act because its dues are not used "principally" for the purposes specified. However, the A.M.A. protects itself by registering and filing pursuant to the Act under protest.

The Act does not apply to any person who merely appears before a Committee of Congress in support of or in opposition to legislation. 2 U.S.C.A., § 267(a). Nor would it apply to communicating one's beliefs as to particular legislation to his Congressmen. Because of the A.M.A.'s compliance with the Act under protest the payment of A.M.A. dues is perfectly safe and proper though eventually professional associations should be held covered by the Act.

Although medical societies are seriously restricted in their direct political actions in elections (as described in the March issue), there is a proper and lawful political vehicle in the political action committee. Physicians can form committees to solicit contributions and give financial aid to particular candidates in Federal elections provided no contribution comes from a corporation, including a medical professional society, and provided the political committee complies with reporting requirements. Such a committee need not comply with the reporting requirements unless it operates in more than one state or is a branch of a national group. Thus, it is clear that groups of physicians may take action outside their incorporated societies with little or no restric-

Prepared at the request of the Medical Association of Georgia. Mr. Moore is an associate in the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.

tion. But it cannot be overemphasized that, to be safe, the arrangements should be carefully examined by the physicians' legal counsel.

Individual physicians, not employees of their societies, may freely engage in political activities, including contributing to campaigns, except that no person may contribute more than \$5,000.00 for any one year or campaign (including primaries) to one candidate. Nor may one contribute more than \$50.00 in any year in more than one state for a candidate without filing an itemized statement of his expenditures with the Clerk of the House of

Representatives. This restriction does not apply to contributions to political committees. There are other minor restrictions.

Physicians employed (under contract and having taken an oath of office) by the Federal Government or any State or local agency supported in whole or in part by Federal funds are prohibited from taking an active part in political arrangement or in political campaigns. 5 U.S.C.A., § 118i, k. The penalty is removal from office. The law applies to full-time, part-time, per diem, and occasional employment. Lengthy provisions of law are applicable to this area and should be carefully scrutinized by physicians employed by Federal, State, or local agencies.

1960 CALENDAR OF MEETINGS

State

May 7-10, 1961—Annual Session, Medical Association of Georgia, Atlanta.

Sept. 29-Oct. 1—Georgia TB Association and Georgia Trudeau Society, DeSoto Hotel, Savannah.

Oct. 12-13—Annual Meeting, Georgia Academy of General Practice, Dinkler Plaza, Atlanta.

Regional

Sept. 14-16—Southern Trudeau Society and Southern Tuberculosis Conference, Hotel Francis Marion, Charleston, South Carolina.

Oct. 31-Nov. 3—Southern Medical Association, St. Louis, Missouri.

Dec. 6-8—Southern Surgical Association, Boca Raton Hotel, Boca Raton, Florida.

National

Nov. 28-Dec. 2—American Medical Association, Clinical Meeting, Washington, D. C.

May 30-June 1—American Gynecological Society, Williamsburg Inn, Williamsburg, Virginia.

June 1-3—Postgraduate Course in Physical Medicine and Rehabilitation in Neuromuscular and Medical Conditions, Denver, Colorado.

June 5-28—Fifth Medical Seminar Cruise, Duke University School of Medicine, to the Baltic, Leaving from Wilmington, N. C. June 5 or New York, June 8.

June 6-24—Forty-fifth Session of the Trudeau School

of Tuberculosis and Other Pulmonary Diseases, Saranac Lake, New York.

June 8-12—American College of Chest Physicians, Miami Beach, Florida.

June 9-10—American Geriatrics Society, Americana Hotel, Miami Beach, Florida.

June 11-12—American Diabetes Association, Inc., Hotel Deauville, Miami Beach, Florida.

June 11-12—Postgraduate Seminar in Arthritis and Related Diseases, Hotel Diplomat, Miami Beach, Florida.

July 20-21—Rocky Mountain Cancer Conference, Hilton Hotel, Denver, Colorado.

Aug. 27-Sept. 1—American Hospital Association, Civic Auditorium, San Francisco, California.

Sept. 1-6—Postgraduate Course in Pediatrics, The Stanley Hotel, Estes Park, Colorado.

Sept. 13-15—National Cancer Conference, American Cancer Society, Inc., and the National Cancer Institute, Minneapolis, Minnesota.

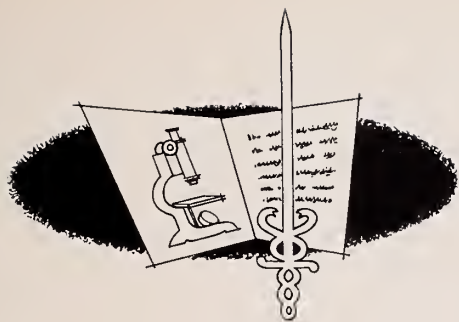
Sept. 24-27—College of American Pathologists, Palmer House, Chicago, Illinois.

Sept. 24-Oct. 2—American Society of Clinical Pathologists, Palmer House, Chicago, Illinois.

Oct. 10-14—American College of Surgeons, Clinical Congress, San Francisco, California.

Oct. 17-20—American Academy of Pediatrics, Palmer House, Chicago, Illinois.

Oct. 21-25—American Heart Association, Inc., Jefferson Hotel, St. Louis, Missouri.



cancer page

A CANCER DETECTION PROGRAM FOR INDUSTRY

A. H. Letton, M.D., *Atlanta*

YOU AND I KNOW that education of the public about cancer helps save lives. We know that many men and women are alive today after having cancer because they were informed regarding symptoms of the disease and went to a doctor before it had spread. We also know that many cancer patients who could have been saved if they had acted in time, came to us too late and, therefore, lost their lives needlessly.

The American Cancer Society makes a concerted effort to reach the various segments of our public with life-saving facts about cancer. Experience has proven that one of the most effective ways for getting this information to the people is through business and industry.

A recent editorial in *Industrial Relations News* urging companies to establish programs of cancer education and detection stated, "... there are only 45 cancer detection centers in the U. S. and only one of these is sponsored by a business concern. . . . The American Cancer Society reports barely a handful of companies have cancer detection programs of any kind."

The editorial further stated:

"This statistic is significant to every personnel administrator, and to management across the board. For U. S. industry has a stake in helping stamp out cancer. Experience has shown that the cost to a

company of a campaign to help achieve this goal is more than compensated for by improved employee morale, and lower turnover, to say nothing of humanitarian benefits.

"A continuing cancer detection campaign could be organized by larger companies singly, or by smaller companies jointly among themselves with the cooperation of local hospitals.

"The campaign, basically, should include a continuing program of education, teaching employees how to detect the earliest signs of the disease, and encouraging them to visit their physicians for regular checkup.

"The next step should be the setting up of regular medical examinations for employees which would include cancer detection tests, either through company medical departments or physicians within the community.

"This year, the American Cancer Society estimates some 100,000 deaths from cancer will occur in the nation's labor force, and some 175,000 new cases of cancer will be detected among these workers. These men and women will lose income totaling about \$150 million in 1960 and U. S. industry will lose 20,000 man years of work by the year's end.

"U. S. industry has the wherewithal to reduce this loss . . . Study after study shows these programs

Approved by Professional Education Committee, Georgia Division, ACS.

prove their value in humanitarian and economic terms for employees as well as for companies."

The editorial cited a cancer education program at West Point Manufacturing Company here in Georgia where the partial results of only three film showings were "25 biopsies . . . Nine cases were found to be

malignant, and seven of the nine are living today, almost three years later."

Cancer education saves lives. Please explain this to the leaders of business and industry in your community. Also, please explain to them they can do something about it. They can duplicate the good work of the West Point Manufacturing Company all over Georgia.

TRANSPORTATION TO MIAMI BEACH CAN BE JUST WHAT THE DOCTOR ORDERED

A TRIP TO MIAMI BEACH for the American Medical Association's annual meeting, June 13-17, can be just what the doctor ordered.

The nation's most modern planes and trains serve the fabulous vacation land, and motorists will find good highways along scenic routes leading to Miami.

Eastern, National, and Northeast airlines offer through flights from New York to Miami. National has non-stop flights aboard DC-8Bs and the Boeing 707 while Eastern features the DC-8B. The jets make the trip in less than two hours and a half.

Eastern also offers non-stop service to Miami via jet-powered Electras from Detroit and Cincinnati and non-stop flights from St. Louis aboard the Super C Constellation.

Capital Airlines flies non-stop to Miami from Buffalo, N. Y., Pittsburgh, Cleveland, and Atlanta.

Delta Airlines has jet flights to Miami from Atlanta. Delta also flies jets from Chicago to Miami and has through service from Detroit, Cincinnati, New Orleans, Memphis, St. Louis, and Dallas, including non-stop flights from major cities.

From the west coast, Northwest airlines offers direct service aboard the jet-powered Electra from Seattle to Miami, stopping only in Chicago. It also has non-stop flights between Chicago and Miami Beach.

Capital Airways flies DC-6Bs non-stop from Los Angeles and Chicago, offering non-stop service from Chicago to Miami aboard Super Constellation.

Also from Los Angeles, American has a non-stop jet flight to Fort Worth where a Delta-National interchange serves Miami with direct flights stopping only in New Orleans.

Railroads

Fast, comfortable travel to Miami also is provided by some of the nation's finest trains.

The Atlantic Coast Line's "East Coast Champion," deluxe streamliner featuring club car, diner, bedrooms and roomettes, leaves New York daily in the afternoon and arrives in Miami the following afternoon. The Seaboard Air Line's streamliner, "The Silver Meteor," runs on a similar schedule between New York and Miami.

From Chicago, the Illinois Central's "City of Miami"

and the Pennsylvania's "South Wind" run on alternate days. Each leaves in the morning and arrives the following afternoon.

The Milwaukee Road runs four crack streamliners from the west coast to Chicago for connections to Miami: the "Olympian Hiawatha" from Seattle, the "City of Portland" from Portland, the "City of San Francisco" from San Francisco, and the "City of Los Angeles" from Los Angeles.

Santa Fe offers deluxe service from Los Angeles and San Francisco into Chicago on the "Super Chief" and "The Chief." The Burlington runs the "California Zephyr" between San Francisco and Chicago and the "North Coast Limited" between Seattle and Chicago.

On the southern route, Southern Pacific's "The Sunset" leaves Los Angeles nightly for New Orleans where connections can be made for Miami.

Highways

For motorists, the American Automobile Association has recommended these routes to Miami from major cities:

NEW YORK TO MIAMI—New Jersey turnpike to Wilmington, Del.; U. S. 40 to Washington; U. S. 1 to Petersburg, Va.; U. S. 301-117-N. C. 403-U. S. 701 to Charleston, S. C.; U. S. 17 to Jacksonville, Fla., and U. S. 1 and/or Sunshine Tollway to Miami.

ATLANTA TO MIAMI—U. S. 41 to Barnesville, Ga.; U. S. 341 to Eastman, Ga.; U. S. 23 to Waycross, Ga.; U. S. 1 to Jacksonville, Fla., and U. S. 1 and/or Sunshine Tollway to Miami.

ST. LOUIS TO MIAMI—Ill. 13-127-3 to Cairo, Ill.; U. S. 51 to Fulton, Ky.; U. S. 45-82 to Albany, Ga.; Ga. 133 to Moultrie, Ga.; U. S. 221-27-19-27 to Ocala, Fla.; U. S. 441-Fla. 68 to Ft. Pierce, Fla., and U. S. 1 and/or Sunshine Tollway to Miami.

CHICAGO TO MIAMI—U. S. 41-30 to Schererville, Ind.; U. S. 41 to Nashville; U. S. 70-21-431-231 to Huntsville, Ala.; U. S. 231-280 to Columbus, Ga.; U. S. 280-Ga. 55-U. S. 82 to Albany, Ga.; U. S. 19-Ga. 133-33-U. S. 221-27 to Perry, Fla.; U. S. 19-27 to Ocala, Fla.; U. S. 441-Fla. 68 to Ft. Pierce, Fla., and U. S. 1 and/or Sunshine Tollway to Miami.



heart page

THE USE OF ATROPINE IN ACUTE MYOCARDIAL INFARCTION

Ernest Proctor, M.D., *Newnan*

THE ROLE OF ATROPINE in the management of acute myocardial infarction has been a mildly controversial subject for some 25 years. In the 1930's it was promoted as being capable of blocking vagus stimulated vasoconstrictor reflexes in the coronary arteries themselves and thereby preventing extension of acute myocardial infarction. Since the early 1940's its usefulness in this regard has been generally denied.

The incidence of AV nodal dysfunction (any of the "degrees" of heart block or AV dissociation) in acute myocardial infarction varies from 15 per cent in some series to as high as 30 per cent in others (Bean, W. D.: *Annals of Internal Medicine* 11:2086, 1938; 12:71, 1938). AV nodal dysfunction is most frequently seen in infarction of the inferior and posterior wall of the left ventricle. One often sees (if he is looking) partial heart block in the patient with inferior myocardial infarction of a few hours duration. One can almost predict it at the sight of the ashen-gray faces, the parasympathetic sweating, and the prompt vomiting after the first dose of opiate. The blood pressure will often be at disturbingly low levels, say, 90/50 or 75/50, and the patient will appear to be in "shock." There may be some irregularity of the pulse or it may simply be slow. More complex rhythm disturbance may develop subsequently since this is the patient who is also prone to paroxysmal atrial fibrillation or atrial flutter or even the fashionable PAT with block (without the instrumentality of digitalis).

The picture just presented is that of an intense

"vagal storm." Similar pictures are seen in clinical circumstances other than acute myocardial infarction. Electrocardiographic monitoring of patients in vasovagal syncope will show a surprisingly high frequency of AV nodal dysrhythmia. It is seen in the otologist's chair during manipulations of the middle ear. Patients undergoing anesthesia in the induction phase commonly go through a period of AV nodal dysfunction, hypotension, and "cold, clammy" (vagal) sweating.

The drug of choice, of course, for such vagal storms is atropine in adequate doses. This is no less true in the situation of acute myocardial infarction. It is surprising how rapidly one can induce a return of color to the face, a cessation of the diaphoresis, a lessening of the nausea, and, most important, *a normal PR interval and a normal blood pressure* with the administration of 1 mg. atropine sulfate in the vein. The dose should be repeated at approximately four hour intervals thereafter for 24-36 hours. There is no special danger in the intravenous administration of atropine sulfate. The time required for action by this route of administration is between seven and 15 minutes. If given in the muscle the time required for maximum action is between 20 and 30 minutes. No one will deny that even mild degrees of hypotension is an undesirable factor in a situation where coronary perfusion is critical. Although studies at the present time are not definitive, there is much evidence to suggest that AV nodal dysfunction or disordered atrioventricular mechanics can significantly reduce left ventricular

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

output and hence coronary perfusion pressure. If for no other reason, the mitigation of nausea with an agent considerably less hazardous than the phenothiazines is much to be desired. It is doubtful that the increase in pulse rate due to atropine is ever in this circumstance prejudicial. Of course, one is liable to atropine idiosyncrasy with mania; however, this is very rare in the adult. One may also have to contend with urinary bladder dystonia and the possibility of a complicating glaucoma.

MIAMI BEACH OFFERS IDEAL CLIMATE, DIVERSE ACTIVITIES FOR A.M.A. MEETING

MIAMI BEACH, A LUSH chain of islets set in the sparkling Atlantic, promises ideal weather and vast entertainment facilities for the 109th annual meeting of the American Medical Association, June 13-17.

The meeting is A.M.A.'s first in Miami Beach since the winter of 1954.

The fabled resort area offers the ultimate in sun and fun—temperatures average from 75 to 85 in June and a variety of activities to fit every taste.

Miami Beach escapes the extremes of heat and cold by virtue of the warm waters of the Gulf Stream and its peninsular location. In summer, the sun is tempered by fleecy clouds and occasional rain.

The beauty of the city is enhanced by the trees, shrubs, and flowers that bloom in abundance in private gardens and public parks.

An estimated 125,000 visitors can be accommodated in Miami Beach at any given time. Including metropolitan Miami, there are a total of 917 hotels and motels with 55,600 rooms.

The waters of the Atlantic and Biscayne Bay offer ample opportunity for swimming, skiing, skin diving, and fishing.

There are miles of beaches dotted with palms, water ski schools, and coral reefs for skin divers to explore. Sail boats and motor boats may be rented.

Fishing boats also are available for charter. One of the most popular sports is Gulf Stream trolling for sailfish, marlin, and other salt-water heavyweights. Fresh-water fishermen will find game fish in bay and inlet waters, such as tarpon from 10 to 150 pounds or more.

Sightseers can enjoy a breathtaking view of scenic residential islands and waterfront estates from the deck of modern cruisers that ply the bay. A glass bottom sightseeing boat, "The Mermaid," also operates from the City Yacht Basin.

For golfers, there are two championship courses in Miami Beach, 12 others in the city of Miami.

Shopping is a pleasant pastime along palm-lined Lincoln Road stretching from the bay to the ocean. Many of the shops are branches of world-famous houses.

For nighttime diversion, Miami Beach features some

The most likely reason for the lack of general acceptance of the use of atropine in acute myocardial infarction is not so much a mistaken rationale as general experience with a less than adequate dose. It is unfortunate that we have accepted the anesthetist's standard "grains 1/150." This is probably sufficient for reducing oropharyngeal and bronchial secretion but it is not an adequate dose for the inhibition of cardiovascular reflexes. The dose used should never be (in the adult) less than grains 1/75th. As much as 2 mgs. is generally well tolerated.

of the nation's top stars and revues at smart supper clubs along with many fine restaurants. Summer menus usually include fish served fresh from the water.

Among the interesting places to go in the Miami area

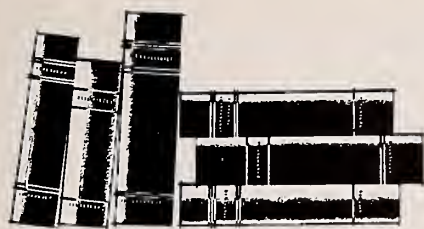


Miami Beach, Florida

is Vizcaya, a magnificent 16th century Italian palazzo which houses the Dade County Art Museum.

The 69-room mansion contains a priceless collection of European and Asiatic art from the first to the 19th century. It is surrounded by 10 acres of formal gardens.

A strictly 20th century show is Miami's "Buildorama" where quality products of the nation's leading builders and manufacturers of home accessories are displayed.



physician's bookshelf

BOOKS RECEIVED

Wansker, Bernard A., M.D., X-RAY AND RADIUM IN DERMATOLOGY, Charles C. Thomas, Publisher, Springfield, Ill., 1959, 114 pp., \$5.00.

Hurst, J. Willis, M.D., CARDIAC RESUSCITATION, Charles C. Thomas, Publisher, Springfield, Ill., 1960, 139 pp., \$5.50.

The Surgeon General, U. S. A., SURGERY IN WORLD WAR II, NEURO-SURGERY, Vol. II, U. S. Government Printing Office, Washington, D.C., 705 pp., \$7.00.

Rule, Colter, M.D., A TRAVELER'S GUIDE TO GOOD HEALTH, Doubleday & Co., Inc., Garden City, N.Y., 1960, 266 pp., \$3.95.

Marti-Ibanez, Felix, M.D., SIGERIST ON THE HISTORY OF MEDICINE, MD Publications, Inc., New York, N.Y., 1960, 313 pp., \$6.75.

Wolstenholme, G.E.W., O.B.E., M.A., M.B., M.R.C.P.; O'Connor, Cecilia M., B.Sc., and O'Connor, Maeve, B.A., CIBA FOUNDATION TENTH ANNIVERSARY SYMPOSIUM ON SIGNIFICANT TRENDS IN MEDICAL RESEARCH, Little, Brown and Company, Boston, Mass., 1959, 356 pp., \$9.50.

Wolstenholme, G.E.W., O.B.E., M.A., M.B., M.R.C.P.; O'Connor, Cecilia M., B.Sc., CIBA FOUNDATION SYMPOSIUM ON BIOCHEMISTRY OF HUMAN GENETICS, Little, Brown and Co., Boston Mass., 1959, 347 pp., \$9.50.

Wolstenholme, G.E.W., O.B.E., M.A., M.B., M.R.C.P.; O'Connor, Maeve, B.A., CIBA FOUNDATION COLLOQUIA ON AGING, VOL. 5, THE LIFESPAN OF ANIMALS, Little, Brown & Co., Boston, Mass., 1959, 324 pp., \$9.50.

Wolstenholme, G.E.W., O.B.E., M.A., M.B., M.R.C.P.; O'Connor, Maeve, B.A., CIBA FOUNDATION STUDY GROUP NO. 3, CANCER OF THE CERVIX, Little, Brown & Co., Boston, Mass., 1959, 114 pp., \$2.50.

Conn., Howard F., M.D., CURRENT THERAPY—1960, W. B. Saunders Co., Philadelphia, Pa., 1960, 808 pp., \$12.00.

Davis, Loyal, M.D., CHRISTOPHER'S TEXTBOOK OF SURGERY, W. B. Saunders Co., Philadelphia, Pa., 1960, 1551 pp., \$17.00.

Hanlon, John J., M.S., M.D., M.P.H., PRINCIPLES OF PUBLIC HEALTH ADMINISTRATION, The C. V. Mosby Co., St. Louis, Mo., 1960, 714 pp., \$10.50.

Gardner, Ernest, M.D.; Gray, Donald J., PhD., and O'Rahilly, M.Sc., M.D., ANATOMY, W. B. Saunders Co., Philadelphia, Pa., 1960, 999 pp.

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

REVIEWS

Ochsner, Alton, M.D., SMOKING AND HEALTH, Julian Messner, Inc., New York, N. Y., 1959, 108 pp., \$3.00.

THIS BOOK IS A short discussion—only 100 pages—on the subject of smoking as a health menace. It contains much statistical material accumulated from the leading health agencies and scientific medical journals. It is written in a very interesting style which certainly provokes much thought as to what effect smoking has on health. Smoking is indicated as a causal factor in cancer of the lung, heart disease, and has some relationship to peptic ulcer. In addition to this, it is pointed out that it does have some deleterious effect to the reproductive system. The final chapter of the book is a plea by Dr. Ochsner to stop smoking or to at least slow down.

Hoke Wommach, M.D.

Ariel, Ervin M., M.D. and Pack, George T., M.D., CANCER AND ALLIED DISEASES OF INFANCY AND CHILDHOOD, Little, Brown Company, Boston, Massachusetts, 1960, 605 pp., \$22.50.

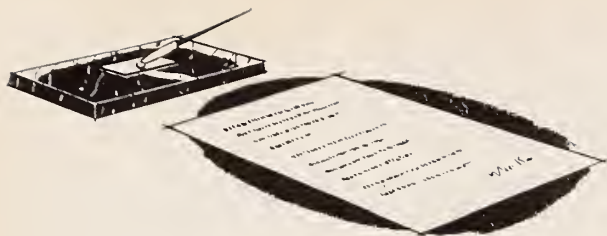
THIS VOLUME IS THE first comprehensive treatise devoted exclusively to the clinical aspect of cancer and allied disease in children.

In their usual astute manner, the authors have catalogized the neoplasms seen in human beings under the age of 15, and have chosen contributing authors of international renown. This combination produces an acme of authority concerning these problems.

In addition to the true neoplasms seen in children, the volume includes an excellent chapter on reticulo-endotheliosis which, while not truly neoplastic, in their manifestation may simulate cancer. While the book is divided according to the regional distribution of various neoplasms, the child as a human entity is never neglected.

The volume is brilliantly done and reflects well the vast experience of the authors. It should be included as part of every medical library and makes excellent leisurely reading as well as encyclopedic.

Neil G. Perkinson, M.D.



abstracts by georgia authors

Gay, Britt B., Jr. and Franch, Robert H., Emory University Clinic, Atlanta 22, Georgia, "Pulsations in the Pulmonary Arteries as Observed with Roentgenoscopic Image Amplification," *Am. J. Roentgenol.* 83:335-344 (Feb) 60.

The use of roentgenoscopic image amplification greatly improves one's ability to visualize intrinsic pulsations in the pulmonary arterial branches within the lungs.

In patients having isolated valvular pulmonary stenosis, a characteristic pattern of pulsation is present. The main and left pulmonary arteries reveal a marked increase in intrinsic pulsation, whereas a diminution or absence of pulsation of the right descending pulmonary artery branch in the right hilus is seen. These roentgenoscopic findings are important signs of isolated pulmonary valvular stenosis and should be added to the other well known clinical and roentgenographic signs. This differential pulsation between left and right hilar areas has not been observed in our patients with pulmonary infundibular stenosis. Roentgenographically, the heart may be normal in size or slightly enlarged, the main and left pulmonary arteries are dilated, and the peripheral pulmonary arterial branches and pulmonary veins are usually normal.

Thomas, Wesley C., 1717 Reynolds St., Brunswick, Georgia, "Obscure Sinus Infections," *Medical Times* 199-206 (Feb) 60.

Seventy per cent of patients having pain in the head can be relieved entirely or improved by treatment of a latent nasal sinus infection. Eighty per cent of these are purely nasal sinus headache, and 20 per cent are a mixed type headache aggravated by obscure sinus infection.

The number of instances of neurosis, vertigo, nasopharyngitis, gastric trouble, and cough cured or improved by nasal sinus treatment causes me to conclude that these are often symptoms of obscure nasal sinus infections. The fact that many have relapses after reactivations of nasal trouble in no way alters this conclusion.

Woodhall, J. P., 724 Hemlock St., Macon, Georgia, "Benign and Malignant Intrathoracic Tumors Simulating Gallbladder Disease," *South. M. J.* 53:145-149 (Feb) 60.

Four cases of pulmonary tumor are described, in which the right eighth

thoracic nerve was either invaded by carcinoma or stretched by a benign neuroma resulting in segmental nerve pain noted by the patient in the right upper quadrant of the abdomen. In each instance this produced difficulty in determining whether or not gallbladder disease was present in the patient.

The fact that abdominal pain may arise from intra-abdominal disease, from extra-peritoneal disease, from the spinal column, and from the thorax is emphasized. The innervations of the various areas are considered and described with the suggestion that the differential diagnosis of abdominal pain should be made with preciseness rather than accepting a diagnosis based upon broad symptom complexes of familiar diseases.

Perdue, Garland D. and Martin, J. D., Jr., Emory Hospital, Atlanta 22, Georgia, "Thermal Burns," *South. M. J.* 53:170-174 (Feb) 60.

A study of 108 burned patients revealed that over 80 per cent of these injuries could be traced to preventable accidents.

The mortality rate was 6.5 per cent. All deaths occurred in patients with burns of more than 55 per cent in extent.

The striking feature of this study was the occurrence of numerous complications related to infection and debility, resulting from the open wound. It is believed that this study indicates the need for earlier closure of the burn wound. Present methods of achieving this were discussed.

Brown, J. H. U. and Ulvedal, Frode, Department of Physiology, Emory University, Atlanta 22, Georgia, "Studies on Ultracentrifuge Fractions of Anterior Pituitary with Special Reference to Adrenocorticotrophic Hormone," *Endocrin.* 66:175-184 (Feb) 60.

Subcellular fractions from the anterior pituitary lobe obtained by ultracentrifugation were analyzed for purity by chemical, enzymatic, and physical tests. After separation of particles was established each fraction was analyzed by a three-dose response method for the hormones present. The hormones of the anterior pituitary occur in separate subcellular fragments; LH and STH in the secretory granules, TSH in the mitochondria, and ACTH in the microsomes and supernatant. FSH is

scattered over several fractions. Treatment of the fractions with acid has little effect on STH while alkali destroys this hormone. TSH activity is destroyed by both acid and alkaline treatment. Acid treatment of the fractions augments FSH activity while it destroys LH activity. Alkaline treatment decreases the activity of the gonadotrophins. ACTH activity is potentiated by acid treatment, which alkaline treatment decreases the activity of ACTH slightly. Analysis of the fractions for hormone content indicates that ACTH comprises one per cent, STH 0.6 per cent, TSH 1.8 per cent, FSH 1.1 per cent, and LH 1.4 per cent of the weight of whole fresh anterior pituitary. On the basis of unitage there were 11 units of ACTH, six per cent STH, 720 units of TSH, 550 units of FSH, and 350 units of LH per gm. of fresh pituitary and six times these amounts per gram of pituitary proteins.

Brown, J. H. U.; LaBella, Frank S., and Ulvedal, Frode, Department of Physiology, Emory University, Atlanta 22, Georgia, "Studies on the Intracellular Localization of Anterior Pituitary Hormones by Means of Differential Centrifugation," *Endocrin.* 66:1-12 (Jan) 60.

Following the development of means for the separation of subcellular particles in anterior pituitary and the establishment of criteria of purity, each of the fractions was analyzed for hormone content and compared with results obtained by others. The fractions were assayed by a three-dose response method for TSH, ACTH, LH, and FSH. TSH was found in mitochondria, LH and STH in acidophilic granules, and FSH was distributed over several fractions. ACTH was found in the microsomes and in supernatant depending on the method of assay adopted. The predominant activity appeared in the indicated fraction, but there was scattered activity over several fractions. The results agree in the main with those of other investigators.

Rosenberg, Donald G. and Galambos, John T., Grady Memorial Hospital, 69 Butler Street, S.E., Atlanta 3, Georgia, "Yellow Spinal Fluid," *Am. J. Digestive Dis.* 5:32-48 (Jan) 60.

Spinal-fluid (CSF) bilirubin, color, protein, cell counts, and sugar were studied in 62 jaundiced patients with infectious hepatitis, leptospirosis, drug-

induced jaundice, chronic intrahepatic disease, benign and malignant extrahepatic obstruction, hemolytic anemia, and undiagnosed jaundice. Both direct and indirect bilirubin was present in the CSF.

Yellow CSF with increased CSF bilirubin was present in some cases in each group. The yellow color of the CSF was not directly or consistently related to the height of the CSF bilirubin. The height of the CSF bilirubin was not related to the duration of jaundice, but was related to the serum bilirubin levels in patients with viral hepatitis and with chronic intrahepatic disease. Such correlation was not demonstrable in patients with extrahepatic obstruction.

The mean of the CSF serum bilirubin ratios was not significantly different in the groups of patients with infectious hepatitis, chronic intrahepatic disease, and extrahepatic obstruction.

The presence of yellow spinal fluid with increased CSF bilirubin cannot be used for the differential diagnosis of jaundice; however, if pleocytosis is also present, it is strongly suggestive of leptospirosis in a jaundiced patient.

CSF protein of 40 mg./100 cc. or more was present in five of 20 patients with infectious hepatitis. An additional four of these 20 patients had PMN's in the CSF, but no pleocytosis was noted. In patients with cirrhosis elevation of CSF protein was associated with hepatic coma or delirium tremens.

There was no significant correlation between CSF bilirubin (direct) and CSF protein level within the group studied.

Bennett, William H., and Morrison, William N., 340 Boulevard, N.E., Atlanta 12, Georgia, "Advantages of Perineal Biopsy of Prostate Prior to Radical Retropubic Prostatectomy," South. M. J. 53:194-198 (Feb) 60.

Experiences with six cases of carcinoma of the prostate treated by radical prostatectomy have been discussed. A two stage procedure, perineal biopsy followed by retropubic prostatoseminal vesiculectomy is recommended. The advantages of perineal biopsy are stressed.

The principal advantages of perineal biopsy followed by retropubic prostatoseminal vesiculectomy are:

- (1) Perineal biopsy is the only truly accurate method of diagnosis.
- (2) Operability can be better determined by palpation of the exposed tissue.
- (3) Evaluation of the prostatic con-

dition and biopsy of regional nodes yields best results in determining operability.

(4) The more difficult vesicourethral anastomosis is accomplished in an operative field familiar to all urologists.

(5) Large adequate biopsy is made available for careful study. (Occasionally all malignant tissue is removed by the biopsy.)

(6) Time is allowed for preparation and study of permanent sections.

(7) Denonvilliers fascia is dissected, shortening the radical procedure remarkably.

(8) Perineal biopsy is well tolerated and causes minimal disability.

(9) Dependent perineal drainage is provided eliminating suprapubic drainage.

(10) Partial incontinence has been easily overcome.

(11) Total incontinence has not occurred.

Wigh, Russell, Medical College of Georgia, Augusta, Georgia, "On Increasing the Versatility of Specialized Equipment," Radiology 74: 77-78 (Jan) 60.

The expanding scope of investigations in roentgenology requires increasing space and more specific equipment to meet specialized requirements. In many departments, neither space nor financial demands can easily be met. As a consequence, perhaps one should take inventory of what he has and try to learn whether modifications of installed equipment may not serve as adequately as would additional units fit only for individual tasks; or, if purchases are to be made, consideration might be given to equipment with multipurpose capacity.

The article outlines a modification of a biplane angiocardigraphic roll-film changer adapting it for biplane cerebral angiography; a curved metal guide plate was added along which an x-ray tube may be moved to obtain 25° angulation for antero-posterior projections of the skull. It discusses the principles of aorto-arteriography in continuity by a patient propulsion technique, including reverse propulsion. The patient is placed on a motor-driven table and after injection of the aorta, is moved over the film changer, successive segments of the vascular tree being recorded. A master control system to facilitate the use of the various pieces of equipment was also designed. Details of construction are to be published in the near future.

Bronson, S. Martin, V.A. Hospital, Atlanta, Georgia, "Idiopathic Pulmonary Hemosiderosis in Adults," Am. J. Roentgenol. 83:260-273(Feb)60.

A case of idiopathic pulmonary hemorrhage in a 27½ year old male, observed for six years from onset of his disease, is described. The typical clinical and roentgenographic findings are discussed.

A preponderance of adult males to females in the ratio of 2.7 to one was reported. The seriousness of the prognosis in this disease is implicit in that 21 of 34 adult cases (in which survival data are available) were dead at the time of writing. The remaining 13 cases were alive for varying periods of one to six years (median 3.5 years) when reported.

All patients, of whom data were available, showed abnormal intrathoracic roentgenographic findings of pulmonary infiltrates except one case which was followed clinically and roentgenographically for 11 months to death.

It should be emphasized that the time interval over which the pulmonary infiltrates change is extremely variable. A negative chest roentgenogram on the first clinical observation of the symptomatic patient can be expected in about one-third of the cases and does not rule out idiopathic pulmonary hemosiderosis. Pulmonary infiltrates, although present initially in two-thirds of the cases, may appear as late as two and one-half to five years following onset of the clinical symptoms but usually occur within 19 days to two and one-half years.

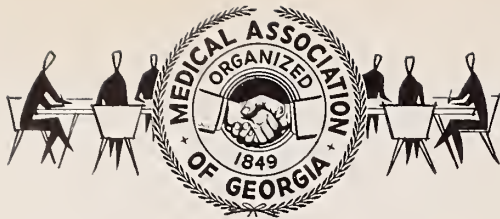
Hemoptysis, anemia of 2 to 7 gm. hemoglobin (microcytic and hypochromic), persistent low serum iron and macrophages in the sputum containing hemosiderin are almost diagnostic of this disease. However, it is pointed out that erythrocytosis may be seen intermittently in a patient who also presents, alternatively in his clinical course, a very low hemoglobin or red blood cell count.

The radiologist has a unique opportunity and an important role in the diagnosis of this disease, if he is aware of the clinical aspects as he evaluates the chest roentgenogram. Although the list of differential diagnosis is impressive, careful scrutiny of the infiltrates, their distribution and variance in time, as well as the clinical laboratory data will facilitate the correct diagnosis. In 29 out of 34 collected cases, the radiologist was able to suggest the diagnosis of idiopathic pulmonary hemosiderosis.

NEW OFFICERS ELECTED

THE ATLANTA RADIOLOGICAL SOCIETY recently elected the following new officers for 1960-1961:
President Dr. James V. Rogers

Vice-President Dr. Chas. Silverstein
Secretary-Treasurer . . . Dr. Wilson T. Edenfield



the association

MEDICARE CONTRACT RENEGOTIATED

The Medical Association of Georgia has renegotiated the Medicare Contract with the Department of the Army up to the period March 1, 1961.

The Medicare Program has been revised as of January 1, 1960. This revision has removed the restrictions placed on the program in October of 1958. Information included in this revision has been distributed to the physicians over the state in the form of Medicare Directive X. The removal of the 1958 restrictions has caused a steady increase in the claim volume handled by Medicare.

Medicare Directive XI, effective February 29, 1960, has been distributed to physicians over the state. Contained in this Directive are the new revisions of the Medicare Contract with the Department of the Army which are of interest to the physicians active in the program. Also contained in Directive XI is information designed to aid physicians in completing claim forms accurately.

ANNOUNCEMENTS

The Georgia TB Association and its medical wing, the Georgia Trudeau Society, will hold its annual meeting September 29 through October 1, 1960, at the DeSoto Hotel, Savannah, Georgia. The medical sessions are expected to be approved for GAGP Credit.

Physicians and their families attending the Annual Meeting of the AMA in Miami, June 13-17, can make advance reservations for post or pre-convention tours and thus be assured that accommodations will be available.

Caribbean tours to Nassau and Jamaica are being arranged for AMA members and their families in advance and are recommended because of limited cruise and air facilities and an expected record meeting attendance.

A special descriptive folder has been prepared and is available by contacting Mr. John Hanni, Jr., Executive Secretary, Dade County Medical Association, 2 S.E. 13th St., Miami 32, Fla.

DEATHS

GEORGE WILLIS HAMMOND, 73, prominent Newnan physician and former Heard countian, died at his home January 11.

Dr. Hammond was born in Chambers County, Alabama and moved to Heard County at the age of two years. He was graduated from Emory University School of Medicine in 1913 and had been in the general practice of medicine for the past 47 years. He practiced in Lowell and Roopeville communities before moving to Newnan 34 years ago.

He was a member of the Newnan Civitan Club, the Official Board of the First Methodist Church, the American Medical Association, the Medical Association of Georgia, and was past secretary-treasurer of the Coweta Medical Society.

Survivors include his wife; three sons, Harold Hammond and Bobby Hammond, Newnan, and Hulett Hammond, Savannah; two sisters, Mrs. G. A. Adams, Franklin and Mrs. J. H. Daniel, Cedartown; a brother, W. D. Hammond, Marion, Ala.; a sister-in-law, Mrs. H. B. Hammond, Augusta, and five grandchildren.

JAMES R. McCORD, 75, professor emeritus of obstetrics and gynecology of Emory University School of Medicine, died March 26 in an Ocala, Fla. hospital.

Dr. McCord, one of the Southeast's most outstanding practitioners and professors in the field of obstetrics-gynecology, had retired from Emory 10 years ago and had lived in Ocala since that time. Born in Conyers, he attended Georgia Tech briefly and earned his medical degree from Jefferson Medical College in Philadelphia in 1909.

He joined the faculty of the Atlanta Medical College in 1912. In 1915 the college became the School of Medicine at Emory University and Dr. McCord served on the faculty until 1946. He served as first full-time chairman of obstetrics and gynecology from 1936-1946 and in 1946 was awarded an honorary Doctor of Science degree by the university.

During World War I, Dr. McCord served in France with the Emory Medical Unit.

Last Spring Dr. McCord was given an award of honor by the Medical Alumni Association of Emory for his contributions to medical education.

In the early days of the Roosevelt administration, Dr. McCord was senior medical officer and special representative of the Children's Division of the U. S. Department of Labor. In this capacity, he traveled all over the Southeast instructing rural doctors in modern obstetric practices.

Dr. McCord helped organize and was the first president of the South Atlantic Association of Obstetricians and Gynecologists. In 1935 he was elected chairman of the obstetrical section of the American Medical Association and in 1939 served as chairman of the American Society of Obstetrical, Gynecological, and Abdominal Surgeons.

He was also a member of the American Gynecological Society, the American College of Surgeons, the American Medical Association, Southern Medical Association, the Medical Association of Georgia, and the Fulton County Medical Society.

Survivors include two sons, James R. McCord, Jr., North Pomfret, Vt. and Walter R. McCord, Louisville, Ky.; two brothers, Harry Y. McCord, Jr., Atlanta and T. A. McCord, Fort Valley, and three grandchildren.

Q. A. MULKEY of Millen, died April 7 unexpectedly at his home.

Born in Girard, he had lived and practiced medicine in Millen for over 50 years.

He graduated from the Medical College of Georgia in 1909, and had operated the Mulkey Hospital for nearly 50 years.

Dr. Mulkey was president of the State Board of Medical Examiners, president of the Burke, Screven, Jenkins County Medical Society, fellow of the International College of Surgeons, member of the Medical Association of Georgia and the American Medical Association, past president of the Jenkins County Livestock Association, and past president of the Georgia Angus Breeders Association.

He was a veteran of World War I, a member of the American Legion, a Mason, and a member of the Millen Methodist Church. In 1959 the Medical Association of Georgia honored Dr. Mulkey with a 50-year pin.

He is survived by his wife; a daughter, Miss Jane Mulkey, Atlanta; a son, Dr. A. P. Mulkey, Millen; four brothers, W. M. Mulkey and D. T. Mulkey, Pompano Beach, Fla., and J. D. Mulkey and E. L. Mulkey, both of Sardis.

SOCIETIES

The Bibb County Unit of the American Cancer Society presented a plaque of appreciation to the BIBB COUNTY MEDICAL SOCIETY recently in recognition of the physicians' arrangement and attendance in 31 booths of the Crusade for Life Cancer Exhibit at Central City park last fall.

The Woman's Auxiliary to the Colquitt County Medical Society recently entertained the COLQUITT COUNTY MEDICAL SOCIETY at a buffet dinner in observance of Doctor's Day.

In observance of Doctor's Day, the Woman's Aux-

iliary to the Cobb County Medical Society entertained the COBB COUNTY MEDICAL SOCIETY.

The COFFEE COUNTY MEDICAL SOCIETY in a special program for Doctor's Day, placed a portrait of the late Dr. Sage Harper in the foyer of the Douglas-Coffee County Hospital.

Recently the Woman's Auxiliary to the DeKalb County Medical Society paid honor to all members of the DeKALB COUNTY MEDICAL SOCIETY at a buffet supper, followed by entertainment including music and dancing.

The Woman's Auxiliary to the Fulton County Medical Society recently honored the FULTON COUNTY MEDICAL SOCIETY with a dinner dance held at the Standard Club.

The regular meeting of the GEORGIA MEDICAL SOCIETY was recently held in Savannah with Dr. Dale Groom, cardiologist at the Medical College of South Carolina, being the principal speaker.

The LAURENS COUNTY MEDICAL SOCIETY recently met and had as their guest speaker Dr. Harold Harrison of Atlanta, formerly of Kite.

Tribute was recently paid to the members of the MUSCOGEE COUNTY MEDICAL SOCIETY by the Woman's Auxiliary to the Muscogee County Medical Society in observance of Doctor's Day.

As a celebration of Doctor's Day the Woman's Auxiliary to the Sumter County Medical Society entertained the members of the SUMTER COUNTY MEDICAL SOCIETY with a dinner recently at the Americus Country Club.

The members of the THOMAS-BROOKS MEDICAL SOCIETY were guests of honor at an outdoor buffet supper, recently held at the home of Dr. and Mrs. Mervin Wine with members of the Woman's Auxiliary to the Thomas-Brooks Medical Society as hostesses.

The members of the Woman's Auxiliary to the Upson County Medical Society recently entertained the members of the UPSON COUNTY MEDICAL SOCIETY with a dinner at the Thomaston Country Club.

Residents of Whitfield County were recently given the opportunity to obtain free polio vaccine shots by the WHITFIELD COUNTY MEDICAL SOCIETY.

The FIRST DISTRICT MEDICAL SOCIETY recently held its annual meeting at the Forest Heights Country Club in Statesboro.

A Cancer Symposium was recently sponsored by the SEVENTH DISTRICT MEDICAL SOCIETY and the American Cancer Society, Georgia Division and was held at the American Legion Home in Lindale.

The NINTH DISTRICT MEDICAL SOCIETY recently met at the Elks Club in Gainesville for a scientific meeting and dinner.

PERSONALS

First District

No news submitted.

Second District

PAUL LUCAS of Tifton was recently the key speaker at a meeting of the Tifton Key Club.

W. P. RHYNE of Albany was recently elected president of the Georgia Society of Ophthalmology and Otolaryngology during the annual meeting of the group at the General Oglethorpe Hotel in Savannah.

Third District

The third annual Bradley Center-sponsored psychiatric symposium which was recently held in Columbus, attracted approximately 80 specialists. LEONARD MAHOLICK, director of the Bradley Center, said the purpose of the symposium is to allot psychiatric workers an opportunity to generate interest in their projects so that advances can be made in the development of psychiatric work throughout the area.

Fourth District

GOODWIN G. TUCK of Covington recently spoke to the Pilot Club of Covington on "Problems of Aging."

W. J. GOWER of Thomaston recently attended the American Academy of General Practice Twelfth Scientific Assembly held at Convention Hall, Philadelphia.

Fifth District

MONTAGUE BOYD, W. E. PERSON, and JAMES C. THOROUGHMAN of Atlanta were recently honored at the annual Emory Medical Clinics program held at the Piedmont Driving Club.

A conference sponsored by the American Medical Association's Committee on Aging and the medical societies from Georgia, North and South Carolina, Tennessee, Alabama, and Florida was recently held at the Dinkler Plaza Hotel in Atlanta. WILLIAM ROTTSMAN, JOHN ATWATER, and JOHN MAULDIN, all of Atlanta, took active parts in this conference.

Sixth District

No news submitted.

Seventh District

JACK M. WALDREP of Rome was recently

awarded his diploma as a specialist in the field of urology by the American Board of Urology.

MAXWELL F. HALL, JR., Marietta, was among the nine new faculty members named by the President of Emory University recently.

Eighth District

Doctors and ministers from the Valdosta area met recently at Pineview General Hospital in an institute on ways of coordinating the spiritual and medical needs of the hospital patient, with RICHARD WINSTON of Valdosta taking part on the panel discussion.

Ninth District

STUART G. BLACKSHEAR of Gainesville has announced his association with P. F. BROWN and P. K. DIXON in Gainesville.

The Piedmont Area Tuberculosis Association held its annual meeting recently with O. C. PITTMAN of Commerce and GEORGE PARKERSON of Winder taking parts on the panel discussion of the Arden House Conference Report on Tuberculosis.

BEN K. LOOPER of Canton moderated a session of a conference held recently in Augusta for a "Symposium on the Hirsute Female," which was under the auspices of the Medical College of Georgia, the Georgia Academy of General Practice, and the Southern Endocrine Society.

RAFE BANKS, JR. of Gainesville was recently awarded a citizenship award by radio station WDUN in Gainesville.

Tenth District

PRESTON D. ELLINGTON of Augusta was recently reelected president of the Augusta Area Tuberculosis Association during their annual meeting held at the Richmond Hotel in Augusta.

GERARD B. CREAGH, BOLLING S. DuBOSE, JR., H. B. HARRIS, JOHN L. BARNER, all of Athens, and ROY WARD, JR., Watkinsville, took part in a discussion at the annual meeting of the Piedmont Area Tuberculosis Association on the Arden House Conference Report on Tuberculosis.

CORBETT H. THIGPEN of Augusta recently discussed "Mental Health in the Business World," at the second annual Institute for Secretaries held in Augusta at the Bon Air Hotel.

POMEROY NICHOLS, JR. of Augusta, has announced the removal of his office to the Augusta Medical Park Building.

POST GRADUATE TRAINING

The Third International Congress of Physical Medicine will be held August 21-26, 1960 inclusive, at the Mayflower Hotel, Washington, D. C. The preliminary prospectus covering the international conference carries in a paper, a scientific exhibit, a scientific film, etc. A detail information on registration, application to present copy of this preliminary program may be had on request by writing: Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical

Medicine, 30 N. Michigan Avenue, Chicago 2, Illinois.

The summer seminar on Basic Aspects of Maternal-Fetal Relationships sponsored by the Department of Obstetrics and Gynecology of the University of Colorado School of Medicine will be held June 27-29, 1960 in Denver, Colo. For further information write to: Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20, Colorado.

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THE COVER

Photograph by Mr. Joe Jackson.

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Luther H. Wolff, Columbus	1959-1960

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4—Virgil Williams, Griffin (1961)
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8—F. G. Eldridge, Valdosta (1962)
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10—Addison Simpson, Jr., Washington (1963)

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3—Willis P. Jordan, Columbus (1961)
4—Jack H. Powell, Newnan (1961)

- 5—Charles S. Jones, Atlanta (1962)
- 6—W. H. M. Weaver, Macon (1962)
- 7—Ralph N. Johnson, Rome (1962)
- 8—James M. Hicks, Brunswick (1962)
- 9—Paul T. Scoggins, Commerce (1963)
- 10—M. A. Hubert, Athens (1963)

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 Ted F. Leigh, Atlanta, *Scientific Exhibits a Meeting Rooms*
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Health Care of the Aging

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OFFICIAL PROCEEDINGS

***106 Annual Session**

of the

MEDICAL ASSOCIATION OF GEORGIA

Municipal Auditorium, Columbus, May 1-4, 1960

First Session, House of Delegates

Second Session, House of Delegates

First General Business Session

Second General Business Session

Third General Business Session

* In 1956 it was brought to the attention of the House of Delegates that the numbering of Annual Sessions was inconsistent with the actual number of sessions. To rectify this mistake, this session, instead of being 110th, is the *106th.

*106th MAG ANNUAL SESSION PROCEEDINGS INDEX

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FIRST SESSION, HOUSE OF DELEGATES

SUNDAY, MAY 1, 1960

THE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker Thomas W. Goodwin, Augusta, at 5:30 P.M. on May 1, 1960, in the Municipal Auditorium, Columbus, Georgia, in conjunction with the *106th Annual Session of the Association.

The invocation was delivered by Speaker Thomas Goodwin.

Speaker Goodwin then called for the preliminary report of the delegates' attendance. Eustace A. Allen, Atlanta, member of the Credentials Committee, reported that there was a quorum of 40 delegates present at this time. A complete report made by the Credentials Committee on the attendance at this first Session of the House of Delegates follows.

Attendance

In a compilation of attendance taken from the official roll, 50 county medical societies were represented by their duly elected delegates or alternates. Twenty-three medical societies were not represented at this First Session. Of a total of 141 authorized delegates from their respective medical societies, the official roll showed 98 delegates present at this First Session.

ALTAMAHA: J. B. Brown; BALDWIN: Melvin E. Smith; BIBB: Rudolph Jones, W. E. Lewis, Jule C. Neal, Jr.; CARROLL-DOUGLAS-HARALSON: Phil C. Astin, R. L. Denny; CHATTOOGA: Wm. P. Martin; CHEROKEE-PICKENS: C. J. Roper; CLAYTON-FAYETTE: T. J. Busey; COBB: Bruce D. Burleigh, Wilbur Clonts; COLQUITT: John P. Tucker; DEKALB: L. C. Buchanan, H. G. Carter, Jr., John M. Schreeder; DOGHERTY: Charles Lamb; EMANUEL: R. J. Moye; FLINT: C. E. McArthur; FLOYD: John D. Tate; FRANKLIN-HART-ELBERT: Wayne Harris; FULTON: John S. Atwater, Wm. W. Moore, Sr., J. D. Martin, Jr., Lamar B. Peacock, Ted L. Staton, Joseph S. Skobba, August S. Turner, Lester Rumble, Jr., J. G. McDaniel, John D. Turner, Hugh Hailey, Joseph Cruise, Albert L. Evans, Don F. Cathcart, J. Harris Dew, Ted F. Leigh, John Mauldin, Marvin Davis, J. Frank Walker, T. Sterling Claiborne, Mark S. Dougherty, Linton Bishop, Eustace A. Allen; GEORGIA MEDICAL: Irving Victor, John L. Elliott, Martha C. Gordy, T. A. Peterson, R. B. Gottschalk, Oscar H. Lott; GLYNN: C. S. Britt, Joseph B. Mercer; HABERSHAM: F. O. Garrison; HALL: Rafe Banks, P. K. Dixon; JACKSON-BARROW: P. T. Scoggins; JASPER: J. N. Pritchett; JENKINS: John R. Harrison; LAURENS: Wm. A. Dodd; CRAWFORD W. LONG: A. P. Keller, Jr., Bothwell T aylor; McDUFFIE: A. G.

LeRoy; MERIWETHER-HARRIS: H. Calvin Jackson; MUSCOGEE: Harry H. Brill, Floyd C. Jarrell, R. A. Chipman, S. A. Roddenbery; NEWTON-ROCKDALE: J. R. Sams; OCMULGEE: Wm. E. Coleman; OCONEE VALLEY: J. H. Nicholson; PEACH BELT: H. E. Weems; POLK: R. F. Campbell; RANDOLPH-TERRELL: Walter D. Martin; RICHMOND: A. J. Waters, David R. Thomas, Jr., W. A. Steed, Wm. E. Barfield, C. I. Bryans, Jr., Wm. A. Fuller, Preston D. Ellington, F. N. Harrison; SOUTH GEORGIA: Van B. Bennett, Robert L. Stump; SOUTHWEST GEORGIA: James B. Martin; SPALDING: Virgil Williams; STEPHENS: I. D. Hellenga; SUMTER: Wm. F. Castellow; THOMAS-BROOKS: William McCollum; TROUP: Charles T. Cowart, H. H. Hammett; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Fred H. Simonton, H. C. Derrick, Jr.; WARE: W. L. Pomeroy, Leo Smith; WASHINGTON: Joseph E. Lever; WAYNE: R. A. Pumpelly, WORTH: W. P. Stoner.

County medical societies not represented at this session of the House of Delegates were as follows:

BARTOW: BEN HILL-IRWIN, BLUE RIDGE, BULLOCH-CANDLER-EVANS, BURKE, COFFEE, COWETA, DECATUR-SEMINOLE, GORDON, GRADY, JEFFERSON, LAMAR, MITCHELL, RABUN, SCREVEN, SOUTHEAST GEORGIA, TAYLOR, TELFAIR, TIFT, TRI-COUNTY, WALTON, WHITFIELD, and WILKES.

Reference Committees

Speaker Goodwin appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE NO. 1: Leo Smith, Waycross, Chairman; W. P. Martin, Summerville, Secretary; A. G. LeRoy, Thomson; T. J. Busey, Fayetteville; W. P. Rhyne, Albany; Rudolph Jones, Macon, and Floyd C. Davis, Waycross.

REFERENCE COMMITTEE NO. 2: T. A. Sappington, Thomaston, Chairman; H. E. Weems, Perry, Secretary; James Martin, Edison; Linton Bishop, Atlanta; W. L. Pomeroy, Waycross; C. J. Roper, Jasper; J. B. T aylor, Athens; M. E. Smith, Milledgeville, and F. N. Harrison, Augusta.

REFERENCE COMMITTEE NO. 3: A. J. Waters, Augusta, Chairman; W. P. Stoner, Sylvester, Secretary; Charles McArthur, Cordele; Robert A. Pumpelly, Jesup; Bruce Burleigh, Marietta; Floyd Jarrell, Columbus; John P. Heard, Decatur, and Henry H. Tift, Macon.

REFERENCE COMMITTEE NO. 4: Jule C. Neal, Macon, Chairman; R. J. Moye, Swainsboro, Secretary; John Tucker, Moultrie; F. O. Garrison, Demorest; L. C. Buchanan, Decatur; John Tate, Rome; J. D. Martin, Atlanta, and A. P. Keller, Athens.

REFERENCE COMMITTEE NO. 5: Rafe Banks, Gainesville, Chairman; Harry H. Brill, Columbus, Sec-

retary; Van Bennett, Valdosta; Charles Cowart, LaGrange; William Fuller, Augusta; Oscar Lott, Savannah; W. E. Coleman, Hawkinsville, and Phil Astin, Carrollton.

Credentials and Tellers Committees

Speaker Goodwin announced the prior appointments of the House of Delegates Credentials Committee and Tellers Committee as follows:

Credentials Committee: J. W. Chambers, LaGrange, Chairman; Eustace A. Allen, Atlanta, and L. M. Shealy, Quitman.

Tellers Committee: William Harbin, Rome, Chairman; S. A. Roddenbery, Columbus, and Harry L. Cheves, Sr., Union Point.

Remarks of the Speaker

Speaker Goodwin called to the attention of the House of Delegates his remarks which were included in the Delegate's Folders. He emphasized that these remarks outlined the ground rules for the conduct of the House of Delegates. Speaker Goodwin in behalf of the House of Delegates then expressed his appreciation to the Muscogee County Medical Society as the host society for these sessions of the House.

Approval of 1959 Minutes

To expedite the reading and adoption of the minutes of the 1959 sessions of the House of Delegates held in conjunction with the *105th Annual Session of the Medical Association of Georgia meeting in Augusta, Georgia, on May 17-20, 1959, the Chair entertained a motion that the minutes as published in the July, 1959 issue of the *Journal of the Medical Association of Georgia* be approved. On motion (Cathcart-Thomas) it was voted that these minutes be so approved.

Memorial Service

Speaker Goodwin then introduced Dr. Frederick S. Porter, former Chaplin of the Medical Center, Columbus, Georgia, who conducted the Memorial Service for the members deceased during the past year. After this moment of prayer, Speaker Goodwin read the names of the departed colleagues:

- T. F. ABERCROMBIE, Decatur, June 14, 1959
- CHAS. R. ADAMS, Atlanta, April 20, 1960
- J. GEORGE BACHMANN, Atlanta, November 28, 1960
- WILLIAM WARD BAXLEY, Macon, November 14, 1959
- P. E. BELL, Sylvester, February 11, 1960
- C. C. BENTON, Macon, August 22, 1959
- W. T. BIVINGS, Atlanta, April 11, 1960
- A. F. BRAUNER, Smyrna, February 27, 1960
- JAMES N. BRAUNER, Atlanta, March 8, 1959
- E. C. BRIDGES, Donalsonville, January 29, 1960
- J. A. BUSSELL, Rochelle, July 15, 1959

- WALTER H. CARGILL, Atlanta, October 26, 1959
- E. J. CURTIS, Columbus, February 29, 1960
- P. H. DIETRICH, Ft. Oglethorpe, February 28, 1960
- J. H. EDGE, Atlanta, January 6, 1959
- H. G. ESTES, Atlanta, June 6, 1959
- W. M. FLANAGAN, Waycross, November 30, 1959
- MAUDE T. FOSTER, Atlanta, July 30, 1959
- C. GLENVILLE GIDDINGS, Atlanta, November 29, 1959
- W. MAYES GOBER, Dial, September 4, 1959
- M. L. GREENE, Monticello, February 4, 1960
- G. W. HAMMOND, Newnan, January 11, 1960
- SAGE HARPER, Douglas, May 26, 1959
- W. B. HARRISON, Athens, July 8, 1959
- H. P. HITCHCOCK, Augusta, August 7, 1959
- K. S. HUNT, Griffin, July 28, 1959
- W. J. HUTCHINS, Buford, November 19, 1959
- BRUCE JACKSON, Newnan, July 28, 1959
- PAUL S. KEMP, Macon, February 23, 1960
- J. M. KENYON, Richland, September 17, 1959
- GEORGE P. KINNARD, Newnan, March 2, 1959
- O. W. KITCHENS, Byromville, June 1, 1959
- L. FIELDING LANIER, Sylvania, May 10, 1959
- A. O. LINCH, Atlanta, February 26, 1960
- J. W. MAYHER, Columbus, July 11, 1959
- JAMES R. McCORD, Ocala, Fla., March 26, 1960
- H. M. McKEMIE, Albany, March 5, 1960
- F. X. MULHERIN, Augusta, March 14, 1959
- Q. A. MULKEY, Millen, April 7, 1960
- BOMAR OLDS, College Park, February 26, 1960
- J. C. PATTERSON, Cuthbert, November 8, 1959
- J. L. PORTER, Rutledge, September 23, 1959
- W. EARL QUILLIAN, Atlanta, November 5, 1959
- F. S. ROGERS, Coleman, June 17, 1959
- T. E. ROGERS, Macon, January 19, 1960
- C. K. SHARP, Arlington, March 12, 1960
- H. F. SHIELDS, Chickamauga, May 8, 1959
- J. W. SIMMONS, Brunswick, May 9, 1959
- D. F. SIRMONS, Dahlonga, December 5, 1959
- C. M. TEMPLETON, Augusta, February 27, 1960
- CLAUDE E. TESSIER, Augusta, September 12, 1959
- BERT TILLERY, Columbus, September 21, 1959
- W. D. WILLCOX, Fitzgerald, October 1, 1959
- W. E. WOFFORD, Cartersville, December 13, 1959

Annual Reports

Speaker Goodwin called for the Annual Reports of the Officers, Council, Councilors, and Committees as the next item of business. (A cross reference of the reports of the Officers, Council, Councilors, Committees, and Allied Reports as introduced at this session is listed below with the Reference Committee to which they were referred. The full report and the action by the Reference Committee and the House of Delegates is listed under the proceedings of the Second Session of the House of Delegates. See pages 265 to 304).

REPORTS OF OFFICERS

- President—Luther H. Wolff, Columbus—Reference Committee No. 1—See Page 266.
- President-Elect—Milford B. Hatcher, Macon—Reference Committee No. 1—See Page 268.
- First Vice President—Corbett H. Thigpen, Augusta—Reference Committee No. 1—See Page 269.

Second Vice President—W. P. Rhyne, Albany—Reference Committee No. 1—See Page 269.

Secretary—Chris J. McLoughlin, Atlanta—Reference Committee No. 2—See Page 273.

Treasurer—Raymond C. Arp, Atlanta—Reference Committee No. 2—See Page 275.

AMA Delegates—C. H. Richardson, Macon; Eustace A. Allen, Atlanta; Henry H. Tift, Macon—Reference Committee No. 3—See Page 282.

Speaker of the House—Thomas W. Goodwin, Augusta—Reference Committee No. 2—See Page 277.

Vice Speaker of the House—Fred H. Simonton, Chickamauga—Reference Committee No. 2—See Page 277.

REPORT OF COUNCIL

Report of Council—J. G. McDaniel, Atlanta, Chairman—Reference Committee No. 3—See Page 283.

REPORTS OF COUNCILORS AND VICE COUNCILORS

First District Councilor—Charles T. Brown, Guyton—Reference Committee No. 3—See Page 288.

Second District Councilor—George R. Dillinger, Thomasville—Reference Committee No. 3—See Page 289.

Third District Councilor—W. G. Elliott, Cuthbert—Reference Committee No. 4—See Page 292.

Fourth District Councilor—Virgil Williams, Griffin—Reference Committee No. 4—See Page 292.

Fifth District Councilor—J. G. McDaniel, Atlanta—Reference Committee No. 4—See Page 293.

Sixth District Councilor—George Alexander, Forsyth—Reference Committee No. 4—See Page 293.

Seventh District Councilor—Ralph W. Fowler, Marietta—Reference Committee No. 5—See Page 299.

Eighth District Councilor—F. G. Eldridge, Valdosta—Reference Committee No. 5—See Page 299.

Ninth District Councilor—Charles R. Andrews, Canton—Reference Committee No. 5—See Page 299.

Ninth District Vice Councilor—Paul T. Scoggins, Commerce—Reference Committee No. 5—See Page 299.

Tenth District Councilor—Addison Simpson, Jr., Washington—Reference Committee No. 5—See Page 300.

REPORTS OF COMMITTEES

Cancer—Hoke Wammock, Augusta, Chairman—Reference Committee No. 4—See Page 293.

Constitution and Bylaws—Thomas W. Goodwin, Augusta, Chairman—Reference Committee No. 5—See Page 300.

Hospital Relations—Milford Hatcher, Macon, Chairman—Reference Committee No. 5—See Page 302.

Crawford W. Long Memorial—Lester Rumble, Jr., Atlanta, Chairman—Reference Committee No. 2—See Page 277.

Maternal and Infant Welfare—Eugene Griffin, Atlanta, Chairman—Reference Committee No. 4—See Page 294.

Medical Defense—Charles S. Jones, Atlanta, Chairman—Reference Committee No. 5—See Page 303.

Medical Education—Charles F. Stone, Atlanta, Chairman—Reference Committee No. 1—See Page 269.

Insurance and Economics—David R. Thomas, Jr., Augusta, Chairman—Reference Committee No. 2—See Page 277.

Mental Health—R. J. Van de Wetering, Atlanta, Chairman—Reference Committee No. 2—See Page 279.

Legislation—J. Frank Walker, Atlanta, Chairman—Reference Committee No. 3—See Page 289.

Professional Conduct—C. F. Holton, Savannah, Chairman—Reference Committee No. 3—See Page 290.

Public Health—H. J. Bickerstaff, Columbus, Chairman—Reference Committee No. 4—See Page 295.

Public Service—John P. Heard, Decatur, Chairman—Reference Committee No. 5—See Page 303.

Rural Health—Albert L. Morris, Fairburn, Chairman—Reference Committee No. 1—See Page 270.

Scientific Exhibit Awards—Ted F. Leigh, Atlanta, Chairman—Reference Committee No. 2—See Page 279.

Veterans' Affairs—Lee Howard, Jr., Savannah, Chairman—Reference Committee No. 3—See Page 290.

Woman's Auxiliary—Virgil Williams, Griffin, Chairman—Reference Committee No. 4—See Page 296.

SPECIAL COMMITTEES

Blood Banks—Lester Forbes, Atlanta, Chairman—Reference Committee No. 1—See Page 271.

Crippled Children—Jack C. Hughston, Columbus, Chairman—Reference Committee No. 2—See Page 280.

Medical Civil Preparedness—Edgar M. Dunstan, Atlanta, Chairman—Reference Committee No. 4—See Page 296.

Radiologic Safety—Robert M. Tankesley, Atlanta, Chairman—Reference Committee No. 1—See Page 272.

Rehabilitation—Robert Bennett, Warm Springs, Chairman—Reference Committee No. 2—See Page 280.

School Child Health—Grady Black, Griffin, Chairman—Reference Committee No. 3—See Page 290.

VFW Liaison—Charles Andrews, Canton, Chairman—Reference Committee No. 4—See Page 296.

Weekly Health Column—August S. Yochem, Atlanta, Chairman—Reference Committee No. 5—See Page 303.

ALLIED REPORTS

Headquarters Office—Messrs. Milton D. Krueger and John F. Kiser, Atlanta—Reference Committee No. 1—See Page 272.

Journal of the Medical Association of Georgia—Edgar Woody, Jr. and Miss Anne Whiddon, Atlanta—Reference Committee No. 2—See Page 280.

Woman's Auxiliary to the Medical Association of Georgia—Mrs. Remer Y. Clark, Marietta, President—Reference Committee No. 4—See Page 297.

At the completion of the report of the Woman's Auxiliary to the Medical Association of Georgia given by Auxiliary President Mrs. Remer Y. Clark, on motion (Peterson-Selman) it was voted that the House of Delegates, acting as a Reference Committee of the whole, duly expresses its appreciation to Dr. William R. Dancy for his origination of the Auxiliary Scholarship Fund for worthy medical students.

General Practitioner of the Year Award

Speaker Goodwin called on Chairman of Council J. G. McDaniel to present nominations received by Council for the 1960 "Georgia General Practitioner of the Year Award." The following names were then presented in nomination: Jack Guy Standifer, Blakely,

nominated by the Southwest Georgia Medical Society and J. F. Mixon, Sr., Valdosta, nominated by the South Georgia Medical Society. Speaker Goodwin then called for nominations from the floor and there being none, he requested that a vote by secret ballot be taken by the House Tellers Committee. Tellers Committee Chairman William Harbin announced the following results: Jack Guy Standifer, Blakely, elected "1960 Georgia General Practitioner of the Year."

Hardman Award

Speaker Goodwin called on Secretary Chris J. McLoughlin who presented nominations received by a Council special committee for the Hardman Award. As one nomination had been withdrawn by the nominee, the single nomination presented by Dr. McLoughlin in behalf of the Council of the Medical Association of Georgia was the Honorable S. Ernest Vandiver, Governor of the State of Georgia. Speaker Goodwin then requested that the nominee be elected by unanimous ballot as cast by the Secretary. He then announced that S. Ernest Vandiver, Governor of the State of Georgia, was elected the 1960 recipient of the "Hardman Award."

Other Business

Speaker Goodwin read a communication of April 12, 1960 from Dr. J. Lafe Ludwig, Chairman of the AMA Council on Medical Services, which praised the services of Dr. David Henry Poer, Atlanta, concerning his activity on the Council on Medical Services. An abstract of this letter reads as follows: "In view of the foregoing, the Council on Medical Services would like to invite the attention of the Officers of the Medical Association of Georgia and, if deemed appropriate, your House of Delegates to the service Dr. David Henry Poer has given the profession through his work on the Committee on

Medical Facilities."

Speaker Goodwin recognized Fred Simonton, Chickamauga, Vice Speaker of the House. Dr. Simonton presented his resignation as Vice Speaker of the House. Dr. Simonton stated that since he had been elected President-Elect of the Association, he wished to resign in the capacity of Vice Speaker of the House. On motion duly made and seconded, the House accepted Dr. Simonton's resignation.

Supplementary Reports

Speaker Goodwin then called for Supplementary Reports which were introduced in the following order:

Supplementary Report of Mental Health No. A: Coverage of Mental Illness—R. J. Van de Wetering, Atlanta, Chairman—Reference Committee No. 2—See Page 279.

Supplementary Report of Council No. B: Social Security—J. G. McDaniel, Atlanta, Chairman—Reference Committee No. 3—See Page 291.

Supplementary Report of Constitution and Bylaws No. C: Annual Session Date—Thomas Goodwin, Augusta, Chairman—Reference Committee No. 5—See Page 302.

RESOLUTIONS

Resolution No. 1: Committee Membership—Southwest Georgia Medical Society—Reference Committee No. 3—See Page 291.

Resolution No. 2: Sterilization—Southwest Georgia Medical Society—Reference Committee No. 3—See Page 291.

Resolution No. 3: Nursing Commission—Fulton County Medical Society—Reference Committee No. 5—See Page 304.

Resolution No. 4: Broadcasting Practices—Fulton County Medical Society—Reference Committee No. 5—See Page 304.

Resolution No. 5: Fluoridation of Water Supply—Muscogee County Delegation—Reference Committee No. 4—See Page 298.

Speaker Goodwin then called for other Resolutions and there being none, on motion duly made and seconded, the first session of the House of Delegates was recessed at 6:10 P.M.

SECOND SESSION, HOUSE OF DELEGATES

(Recessed)

WEDNESDAY, MAY 4, 1960

THE SECOND SESSION (Recessed) of the House of Delegates of the Medical Association of Georgia held in conjunction with the *106th Annual Session of the Association was called to order by Speaker

of the House Thomas W. Goodwin, Augusta, at 9:05 A. M. in the Municipal Auditorium, Columbus, Georgia, on May 4, 1960.

Speaker Goodwin called on Credentials Commit-

tee Chairman J. W. Chambers for a preliminary report of attendance. Dr. Chambers reported that more than 40 registered members of the House were present and Speaker Goodwin declared a quorum present and accounted for and the House in Session. Dr. Chambers later made the following complete report on attendance.

Attendance

In a compilation of attendance taken from the official roll, 30 county medical societies were represented by their duly elected delegates or alternates. Forty-three county medical societies had no representatives at the Second Session. Of a total of 141 authorized delegates from their respective county medical societies, the official roll showed 70 delegates present at this Second Session.

BALDWIN: Melvin E. Smith; BIBB: Henry H. Tift, Jue C. Neal, Jr.; CARROLL-DOUGLAS-HARALSON: Phil C. Astin, Jr.; CHATTOOGA: William P. Martin; CHATTAHOOCHEE: D. C. Kelley; COBB: Bruce D. Burleigh, Wilbur T. Clonts; COLQUITT: John P. Tucker; DeKALB: H. G. Carter, L. C. Buchanan, John P. Heard; DOUGHERTY: Charles C. Lamb, W. P. Rhyne; EMANUEL: R. J. Moye; FLINT: Charles E. McArthur; FULTON: Irving L. Greenberg, Henry E. Steadman, Albert Evans, Linton Bishop, Jr., J. G. McDaniel, Ted F. Leigh, Edwin C. Evans, John Mauldin, T. Sterling Claiborne, Thomas J. Anderson, Jr., Joseph S. Skobba, J. Frank Walker, August Turner, Ted L. Staton, Joseph L. Girardeau, Lester Rumble, Wm. W. Moore, Jr.; GEORGIA MEDICAL: John L. Elliott, Oscar H. Lott, Martha C. Gordy, T. A. Peterson; GLYNN: C. S. Britt; HABERSHAM: F. O. Garrison; HALL: P. K. Dixon, Rafe Banks, Jr.; JACKSON-BARROW: P. T. Scoggins; CRAWFORD W. LONG: Bothwell Traylor; McDUFFIE: A. G. LeRoy; MUSCOGEE: Floyd C. Jarrell, Charles R. Smith, R. A. Chipman; RANDOLPH-TERRELL: Walter Martin; RICHMOND: W. A. Steed, Wm. A. Fuller, Preston Ellington, A. J. Waters, Wm. E. Barfield, David R. Thomas, Jr., C. I. Bryans; SOUTH GEORGIA: Robert L. Stump, Van B. Bennett; SOUTHWEST GEORGIA: James B. Martin; SPALDING: George T. Henry, Virgil Williams; STEPHENS: I. D. Hellenga; TROUP: H. H. Hammett, Charles T. Cowart; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: H. C. Derrick, Jr., Fred H. Simonton; WARE: Leo Smith, W. L. Pomeroy, Floyd Davis; WORTH: W. P. Stone.

County medical societies not represented at this Second Session of the House of Delegates are as follows:

ALTAMAHA, BARTOW, BEN HILL-IRWIN, BLUE RIDGE, BULLOCH - CANDLER - EVANS, B U R K E, CARROLL - DOUGLAS - HARALSON, CHEROKEE - PICKENS, CLAYTON - FAYETTE, COFFEE, COWETA, DECATUR - SEMINOLE, FLOYD, FRANKLIN-HART-ELBERT, GORDON, GRADY, JASPER, JEFFERSON, JENKINS, LAMAR, LAURENS, MERIWETHER-HARRIS, MITCHELL, NEWTON, OCMULGEE, OCONEE VAL-

LEY, PEACH BELT, POLK, RABUN, SCREVEN, SOUTHEAST GEORGIA, SUMTER, TAYLOR, TELFAIR, THOMAS - BROOKS, TIFT, TRICOUNTY, WALTON, WARREN, WASHINGTON, WAYNE, WHITFIELD, and WILKES.

Other Business

Speaker Goodwin recognized Mrs. Remer Clark, Marietta, President of the Woman's Auxiliary to the Medical Association of Georgia. Mrs. Clark expressed, in behalf of the Woman's Auxiliary, appreciation for an office in the new Headquarters building and also the appreciation of the Auxiliary for the appointments of Auxiliary members in an ex-officio capacity to certain MAG Standing Committees.

Speaker Goodwin then called for the election of a Vice Speaker of the House to fill the unexpired term of Vice Speaker Fred Simonton, Chickamauga, who had previously resigned this office at the first session of the House. Speaker Goodwin called for nominations and Charles McArthur of Cordele nominated J. Frank Walker of Atlanta. This nomination was seconded by Eustace A. Allen, Atlanta; Ted F. Leigh, Atlanta, and Fred Simonton, Chickamauga. Speaker Goodwin called for other nominations and there being none, he declared J. Frank Walker of Atlanta elected by unanimous ballot, as cast by the Secretary, to the office of Vice Speaker of the House to fill the unexpired term running until 1962.

Speaker Goodwin then expressed the appreciation of the MAG House of Delegates to the Muscogee County Medical Society and the citizens of Columbus, Georgia, for their hospitality on the occasion of the *106th Annual Session.

Speaker Goodwin then called on the Chairmen of the Reference Committees to present their reports.

Report of Reference Committee No. 1

Leo Smith, M.D., Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 1 met at 8:00 A. M., May 2, 1960, in Room 710 of the Ralston Hotel, Columbus, Georgia. Members present were: Leo Smith, Waycross, Chairman; W. P. Martin, Summer-ville, Secretary; A. G. LeRoy, Thomson; T. J. Busey, Fayetteville; W. P. Rhyne, Albany; Rudolph Jones, Macon, and Floyd C. Davis, Waycross.

President

LUTHER H. WOLFF, Columbus

In 1892, an Annual Conference of the Medical Association of Georgia was held in Columbus. Ac-

counts of the proceedings of this meeting, the first to be held in Columbus, afford an interesting comparison of medicine then and today.

In that golden and leisurely age, characterized by high hats and Prince Albert coats, by erudite and scholarly presentations, and by vast and majestic gastronomical feats, life seemed simpler in many respects. Physicians of that period were able to direct their attentions solely and wholly to medical matters, and concentrate on problems of health and disease.

The Problem

Medicine today has the same solicitude and concern for health and disease that it had in this previous era. Indeed, the complexities and ramifications of medicine today are of such magnitude that they can profitably occupy the entire intellect and action of any physician, without the distractions and interferences of other affairs. Any physician worth his salt would welcome such a circumstance. We physicians cannot, alas, do so! We are not allowed to do so! We are plagued and beleaguered by forces and individuals who would control and usurp us. In order to practice medicine in the manner proven to be best for our fellow human beings, we are compelled, in pure self defense, to devote a substantial portion of our energy and vigor in repelling these malign influences. The point has been reached where some of our larger societies devote entire meetings to these grave socio-economic problems and decisions that constantly confront us. Only by unyielding and concerted efforts can the medical profession hope to retain its honored position and rightful place as the guardian of the health of our people. Those individuals active in organized medicine appreciate this point fully.

This year as President of the Medical Association of Georgia, and therefore as a part of organized medicine, I have directed my efforts largely toward one fixed and unwavering goal—preservation of the private practice of medicine.

The Solutions

There are unquestionably many channels through which the medical profession can and does strive to maintain its cherished freedom of practice. Issues, such as the Forand bill can be attacked forcibly and directly. Other factors, of long range effect, may be of greater significance and ultimate scope in preserving the freedom of medical practice than the spasmodic, intensive efforts focused against the Forand bill. We, as physicians, must evince a probity and integrity in our practice that is above reproach. This, naturally, connotes the highest degree of honesty, fairness, and compassion in our associations with out-patients, not only from the medical aspects, but also from social and economic viewpoint.

Physicians must continue to be good, useful citizens, taking an active part in the civic and political phases of community life. Every effort must be made to keep the respect and confidence of our local, state, and national representatives in government.

There has been excellent rapport during the past year between our State officials and the medical profession. A most gratifying atmosphere of cooperation and mutual respect has existed in many official dealings with the

Governor, the Department of Education, Vocational Rehabilitation, the State Department of Health, and various state and national legislators. The Medical Association of Georgia has gained the reputation, I believe, of being an organization that can furnish qualified men, good advice, and pertinent recommendations on issues having medical aspects.

Accomplishments

The membership at large of the Medical Association of Georgia has responded magnificently in the fight against the serious threat of governmental control to our way of life posed by the Forand bill. The Officers, Staff, Legislative Committee, and the Committee on Aging, have all performed superbly in providing leadership and direction against this imprudent legislation. For example, the Legislative Committee's Annual Washington trip is of singular value in acquainting our Georgia Senators and Representatives in Congress with our views and thinking and in providing an atmosphere of mutual trust and understanding.

The Committee on Aging, has performed most effectively in one short year. With the help of various MAG Committees and other organizations and individuals, the Committee on Aging has pretty well crystallized the solutions to the aging problems. When the time comes for reports and recommendations, Georgia will be ready.

Two exceptionally profitable meetings were held during the past year. One, sponsored by the Legislative Committee of the Medical Association of Georgia, was held primarily for County Society Officers. Doctor Dale Alford was the principal speaker and gave a stirring address. The other, a Southeastern Regional Conference on Aging, sponsored by the American Medical Association with the Medical Association of Georgia being the host society, was a two day meeting featuring a wide variety of excellent speakers. Members of the Medical Association of Georgia did more than their proportionate share in assuring the success of this meeting.

The Conference for County Society Presidents and Secretaries was sponsored again this year by the Public Service Committee and held on February 14, 1960. Atrocious "Yankee weather" prevented our northern counties from sending representatives, but even under such adverse conditions, the meeting was a great success. Congressman Jack Flynt, from the 4th District, presented a masterful address on "The Physician's Role in Government."

A remarkable and significant upheaval in the Mental Health field occurred during the past year. The Governor of Georgia, the Legislature, the Department of Health, the Advisory Committee on Mental Institutions, the Mental Health Association of Georgia and the Press did yeoman service in making drastic changes and plans to ameliorate the dreadful situation prevailing in our State Mental Institutions. These changes followed, to a large extent, recommendations made by the special MAG Committee (The Schaefer Committee) appointed at the request of the Governor in April, 1959. As one of the representatives from the Medical Association of Georgia on the Advisory Committee, I can report that this Committee, composed preponderantly of MAG members, has functioned most effectively, and, in my opinion, should be continued indefinitely.

The Medical Association of Georgia apparently oc-

cupies a very favorable position in AMA circles. The AMA Staff, Officers, and Committee Representatives seem delighted to visit Georgia and all have a very high regard for the Medical Association of Georgia, its members, and staff. Our Delegates to the AMA are held in general esteem, and their opinions are given serious attention. At the 1959 AMA Convention in Atlantic City, the Georgia delegation led the fight against the inclusion of physicians under Social Security. New York, Pennsylvania, New Jersey, Connecticut, and other States presented a formidable array of opposition, submitting resolutions that provided for inclusion of physicians under the Social Security program. The Georgia delegation hurriedly drew up an emergency resolution in compliance with instructions issued by the Medical Association of Georgia House of Delegates in 1959. Since your President had in his possession certain pertinent information he was appointed by the delegation to present and argue Georgia's counter-resolution before the Reference Committee. The support our resolution received from heretofore inarticulate representatives of other states was astonishing. The result was that both the Reference Committee and the AMA House of Delegates adopted the Georgia resolution overwhelmingly.

My term of office as your President has greatly enhanced my esteem of and regard for my medical colleagues. Visits to the various districts and county societies has engendered an awareness of the excellent morale of physicians in general. There is a spirit of friendship and camaraderie among the doctors which did not prevail in the past generation. One does not encounter petty and vicious professional jealousies which existed in the past. Possibly, the threat of socialization and other grave issues has tended to make us forget personal and trivial animosities, and has produced a more united front, upon which the very essence of our future welfare depends.

I wish to express my gratitude to the membership of the Medical Association of Georgia on the selection of the officers and councilors who have so ably served with me this year. These men have uniformly represented you in a most sagacious and thoughtful manner. Their decisions and actions have shown mature thought and sound judgment throughout the year. Although the work of certain committees has been singled out for a special remark in this report, I am fully aware of the splendid performances of many standing and special committees. I am indeed grateful for their help and cooperation. Our committees are the backbone of the Medical Association of Georgia, and I want to give to each the credit it so justly deserves.

I cannot over emphasize the magnificent work of our Headquarters Staff, particularly our executives, Mr. Milton Krueger and Mr. John Kiser. These men have offered invaluable assistance. It is through their efforts that the plans and policies inaugurated by the Officers and Councilors of the Medical Association of Georgia are carried out. These executives are ably assisted by a competent and conscientious staff of office workers.

On January 1, 1960, the Medical Association of Georgia took formal possession of the recently purchased Headquarters Building located at 938 Peachtree Street. Members may take pride in the possession of a building that serves our needs so admirably. It is gratifying to all that a down payment of more than

four-fifth's of the total cost of the building has been made this year.

The past year has been a period that has been most interesting and gratifying. I want to express my deepest appreciation to the Muscogee County Medical Society and to the Medical Association of Georgia both as individuals and as organizations for permitting me to experience the position that I held. I also want to thank my fellow Officers and Councilors, the Committee Chairmen and members, and the Staff for the gracious assistance and advice they have given me.

My congratulations are extended to the Medical Association of Georgia for its choice of Officers and Councilors for the coming year. Your President-Elect, Milford Hatcher, is a man of unusual capabilities, and under his leadership the Medical Association of Georgia will continue to play a most vital role in the medical affairs of our State and Nation. I pledge to him and to you, the members of the Medical Association of Georgia, my continued and fullhearted support and assistance.

REFERENCE COMMITTEE RECOMMENDATION—Dr. Wolff is to be highly commended for his many efforts in behalf of the MAG during the past year. His accomplishments have been many and it is felt that they will be lasting in scope. We particularly would like to compliment him for the work he has done in combating "Forand type" legislation.

HOUSE OF DELEGATES ACTION—Adopted the report of the President as recommended by the Reference Committee on motion duly made and seconded.

President-Elect

MILFORD B. HATCHER, Macon

Your President-Elect has attended as many committee meetings and other meetings as possible, in order to prepare himself for the job as President of your Association. He has attended all of the Council meetings and visited a number of district and county medical societies. He has had discussions with groups as well as individual members of the Association as regards aims and desires of the members, attempting to correlate their thinking so that during his tenure of office he might be of better service to the Medical Association of Georgia.

A number of suggestions are submitted for your consideration, although some of the facts have been brought to the attention of the appropriate committees and work has begun on some of the recommendations. It is hoped that some of the others will progress in the future.

It is known that the biggest problem facing medicine today is "Forand type legislation," or any plan toward socialization of medicine. It has been the general opinion of the majority of physicians interviewed that medicine has been on the defensive, and it is felt that our delegates should ask the House of Delegates of the AMA to take the offensive and bring out some constructive program, particularly for the care of the aged.

A number of physicians have resented the way that the term "doctor" is used and feel that our delegates to the AMA should bring this subject to the AMA House of Delegates and, if necessary, change the title by which M.D.'s are called, and that there be patented an emblem to be used only by physicians.

Georgia has continually favored the medical profession not entering social security, but now with a very

good chance of passing (at this writing) the "Keogh bill," it is felt that the AMA should propose or present some program of "retirement" to take the place of the Social Security Plan; if not, then our state organization itself should institute some workable system for supplementing income for physicians during their later years.

It has been suggested that the Medical Association of Georgia investigate the possibility of establishing a Burn Center to which the severely burned patients be transferred as soon as feasible.

REFERENCE COMMITTEE RECOMMENDATION—Dr. Hatcher is commended for his past efforts and we look forward with pleasure to having him as President in the coming year. We recommend that he pursue the establishing of a Burn Center and continue with his efforts in opposing "Forand type" legislation.

HOUSE OF DELEGATES ACTION—Adopted the report of the President-Elect as recommended by the Reference Committee on motion duly made and seconded.

First Vice President

CORBETT H. THIGPEN, Augusta

It is with great pleasure that I have served as First Vice President of the Medical Association of Georgia for the year 1959-60. I think it is all too often that the members of the medical profession think of their officers as being "political doctors." I have found the members of Council not only to be the finest sort of men but also true physicians. The caliber of the men whom I have met at the Council meetings has made a lasting impression on me. I have found that the business of the Association is not only interesting but vital to the future of medicine. I would like to urge that every doctor in the state read carefully the reports of Council as published in the *Journal*. I dare say that relatively few doctors realize the great amount of work that has gone into these reports by dedicated men. I think it has been all too often that these reports have been neglected by the medical profession at large.

Much of my work during the past year has been to establish a closer liaison between the Student American Medical Association and the American Medical Association. I've had the privilege of meeting with numerous Student American Medical Association chapters over the eastern United States. I have always stressed the importance to these chapters of obtaining a closer relationship with their state medical association. I believe that our medical students and residents represent the future of American medicine, and there is a genuine need for these two organizations to take an interest in one another's affairs so that they can work together to protect the interests of the people and of medicine.

REFERENCE COMMITTEE RECOMMENDATION—Dr. Thigpen is to be complimented for his efforts in behalf of the MAG. Reference Committee No. 1 recommends that efforts be made to send student representatives from each of our Student American Medical Association chapters to AMA meetings.

HOUSE OF DELEGATES ACTION—Adopted the report of the First Vice President as recommended by the Reference Committee on motion duly made and seconded.

Second Vice President

W. P. RHYNE, Albany

Membership on the Council is a proviso that the

Second Vice President should be proud to accept, for here it is that the inner workings of the Association are taking place and much can be learned from attending the Council meetings.

It was my pleasure and privilege to attend the last two meetings of the Council—the meeting at Pine Mountain in October and the Valdosta meeting in January. Other commitments prevented my attending the Dalton meeting last summer.

It was found that considerable business was transacted at these meetings, and much of the vital workings of the Association had beginning and continuation within the Council.

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 1 accepts the report of Dr. Rhyne and commends him for his work during the year.

HOUSE OF DELEGATES ACTION—Adopted the report of the Second Vice President as recommended by the Reference Committee on motion duly made and seconded.

Medical Education

CHARLES S. STONE, M.D., *Chairman*

I. Medical Schools

(a) There seems but little question that more medical schools are needed with the anticipated increase in population in this country. It is estimated that we may require at least 50 per cent more doctors in the next 10 to 15 years.

(b) The present medical school capacity should probably be increased but this is very difficult, expensive, and has limiting factors in teaching personnel and patient facilities.

(c) Ancillary services, such as nurses, technicians, and all types of medical assistants, are just as short in supply as are doctors themselves and we must all become conscious of this and encourage people to go into these fields.

(d) The quality of medical students may be deteriorating. It is of interest that some 10 years ago about 40 per cent of college graduates applying for medicine were in the "A" student category. In the past two years only 19 per cent to 20 per cent of people applying for medical school had this scholastic standing. The demand for places in medical school has dropped off considerably in the last 10 years, and perhaps is one-half to one-third of what it was 10 to 15 years ago.

(e) Perhaps we, as doctors, are not "selling medicine" to prospective students as we should. Perhaps other fields are more appealing, e.g., electronics, advanced physics, mathematics, research programs, and certain business opportunities. There can be but little question that the financial return is quicker in some other fields, and this may play a part in attracting potential doctors to other lines of work.

Medical education itself is getting more complicated, more involved, takes more time and money, and these trends may discourage people from going into medicine.

Some practical ways to shorten the long road to practice must be evolved. New techniques in the audio-visual field are helpful. More recently, attempts at radio education as a means of keeping up to date, have been tried. Still, an organized, concerted attempt to streamline medical education is urgently needed. This may

necessitate a completely new philosophy of medical education.

II. Hospital Training Programs

(a) All hospital training programs probably can stand improvement no matter how good they are. You and I, as practicing physicians, can greatly facilitate this if we will take time to maintain a better liaison with the house officer or extern than we do. This means discussing with him his work-up of each patient, and seeing that he follows up the case well until time of discharge. You may teach him something but it is equally likely that you will learn more than you teach. In any event, patient care will be improved and your training program will be better.

(b) Some hospitals have complained about the inability of certain foreign graduates to speak understandable English. Steps are being taken to correct this by insisting that all foreign graduates have a good command of the English language.

(c) Most hospital staff meetings can likewise be improved by attention to education as the basic function, and not a dry, statistical committee report on some hospital activity.

III. Medical Societies

Each medical society in the State has its own individual problems and must use its own unique solutions—again with emphasis on education as the primary item on the agenda.

IV. Conclusions

As members of the Medical Association of Georgia, each physician has some responsibility in continuing medical education, both his own and that of others.

The problems are tremendous and the solution difficult, but we must all begin to think toward the future and try to project some practical plans.

Each of us can help if he will think about these matters and will send any suggested solutions for improvement to the Medical Education Committee. WE NEED YOUR HELP.

REFERENCE COMMITTEE RECOMMENDATION — Charles F. Stone is to be complimented for his thorough evaluation of the problem of medical education. Reference Committee No. 1 is in accord with his feelings concerning this problem.

HOUSE OF DELEGATES ACTION—Adopted the report of the Medical Education Committee as recommended by the Reference Committee on motion duly made and seconded.

Rural Health

ALBERT L. MORRIS, M.D., *Chairman*

The members of the Committee for Rural Health beg to report that the Committee has functioned well during the year 1959-60. Various projects have been completed, while others are in the to-be-completed category. Attendance at the various meetings has been good and all members have given their whole-hearted support at all times.

A. Accomplishments for the year are:

1. *Insurance Pamphlet*—By this time, almost all physicians in the State have received, along with their membership card for the current year, a pamphlet on Health Insurance. These were instigated by the Committee on Rural Health in an attempt to explain in lay language the various types of insurance. All for the purpose of helping the rural citizen in purchasing the type

of insurance he desires. The Committee is indebted to the Agricultural Extension Service for the distribution of some 10,000 of these pamphlets to the citizens of Georgia.

2. *Poison Centers*—The Committee on Rural Health was able to assist the Department of Public Health of the State of Georgia in establishing Poison Centers over the State. These centers are maintained in key hospitals in the larger cities of the State (some eight or nine cities) and consist of up-to-date data on all the newer agricultural or other chemical poisons. A person is on duty at all times and information is readily available to the physician simply by a telephone call. These centers are under the direct control of the Public Health Department, and they are responsible for keeping the data on poisons current.

3. *Standardized Health Forms*—Prior to this time, various youth organizations having summer encampments in the State have had little or no standardized information available to the authorities of the place of encampment. As a result, it is sometimes very difficult to render specific treatment to a patient until consent has been obtained from the parents. Under the leadership of Dr. Charles E. McArthur, member of the Committee, a standardized form has been produced and adopted by almost all youth organizations of the State. This form will give all pertinent information about the patient, and will allow the authorities to render specific treatment with prior parental consent.

4. *Medical Laboratory Assistants Training*—At the last annual session, the Medical Association of Georgia consented to give approval to a course of training at the Clarkesville Vocational and Trade School, on a one year basis. The School had acted in good faith, and had procured equipment and facilities in the excess of some \$15,000.00 to start such a course of training. During the year great strides forward have been made. A meeting was held at the Academy of Medicine on June 28, 1959 and attended by representatives from the Georgia Association of Pathologists, Georgia Society of Medical Technologists, Georgia Department of Public Health, North Georgia Trade and Vocational School, and the Rural Health Committee. Here it was agreed that students must have the following qualifications: high school graduate with chemistry or its equivalent, ranking in the upper one-third of the class, rating in an aptitude in the 40 percentile, approval of each applicant by the Admissions Board and Advisory Committee, and acceptable personal references with a transcript of high school accreditation. The Advisory Committee was to be composed of members from the following organizations: Georgia Association of Pathologists, Georgia Society of Medical Technologists, Georgia Hospital Association, Georgia Department of Public Health, North Georgia Trade and Vocational School, and Rural Health Committee, Medical Association of Georgia.

As a result of this meeting, the following were appointed to the Advisory Committee: Sister Andrew Josephine, representing the Georgia Society of Medical Technologists; John Godwin, M.D., representing the Georgia Association of Pathologists; Mr. Millard Wear, representing the Georgia Hospital Association; Miss Pattisue Jackson, representing the Georgia Department of Public Health; Mr. H. O. Carlton, representing the North Georgia Trade and Vocational School, and A. L. Morris, M.D., representing the Rural Health Committee.

This Committee held a meeting at Clarkesville on August 9, 1959 and at this time agreed upon a proposed curriculum, ethics, admission mechanism, and performance control along with the training hospitals.

During the interim since this meeting and because of the interest and hard work of Mr. Millard Wear and Mr. Glen Hogan of the Georgia Hospital Association, sufficient hospitals over the State have expressed their willingness to provide facilities for clinical training in their hospitals.

A qualified instructor has been secured, and with this report, the course of study is about ready to be offered to those students that can meet the requirements. It is to be emphasized that this course of study is to be only for Laboratory Assistant training and will not, nor cannot be made to substitute for a Registered Medical Technologist in any way. This course of study is offered to train qualified applicants in *minor* procedures, and these applicants will be informed in their personal interviews of the differences existing in this course of study and in that of a Registered Medical Technologist. This course of study is offered for the purpose of aiding the physician in supplying an office assistant, in aiding the Technologist in the hospital in providing an assistant. It is the belief that this course of study will materially aid the medical family of the State of Georgia. The Committee urges strongly continued approval of this course of study.

B. Projects for the Future are:

1. Sectional Meetings for the National Rural Health Council—At the recent meeting of the National Council of the American Medical Association, it was suggested that there will be a Sectional Meeting in Atlanta, Georgia during the fall of 1960. This meeting will be attended by representatives from all the Southeastern United States. It will be the responsibility of the State Rural Health Committee to play host and to provide such other help as is feasible.

2. Closer liaison with the American Medical Association and other Governmental Agencies to prevent the farmers of Georgia from suffering financial loss over the use of commercial poisons, etc. Particular reference is made to the cranberry episode. It will be the duty of the Committee on Rural Health to provide necessary help in giving medical advice and other means toward this goal.

3. Closer liaison with the Georgia Dental Association in promoting fluoridation of water. This is primarily a function of the urban rather than the rural dweller; however, more and more people are taking up their abode in the rural areas surrounding the larger cities, and as such affect the interest of the Committee.

4. Interest in the problem of the aged continues to occupy a great amount of thought of the committee. It must be repeated, that the problem sometimes is more acute in the rural areas because the per capita income is much less, the facilities offered for medical care and housing, etc., is often times inadequate when compared to that offered by the city. The Committee will continue to offer aid in every possible way toward coming to some logical means of caring for this problem.

5. The Committee will watch with keen interest the project of accreditation of the smaller rural hospitals of the State. Better medical care at home is the goal of

each and everyone of us. We urge special commendation toward this project.

6. The Committee urges continued support to the program of study prescribed for Medical Laboratory Assistants at the North Georgia Trade and Vocational School. We believe this is a needed and most valuable adjunct to the medical picture of the State. It is proving successful in other states and can do so in Georgia.

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 1 feels that this Committee has made great strides in establishing poison centers throughout the state. The Committee also approves the recommendation that standardized health forms be formulated for the use of youth organizations. We further recommend to the House of Delegates that the approval of the Clarkesville Vocational and Trade School be continued for another year. We approve the projects for the future and recommend that these projects be pursued and expanded.

HOUSE OF DELEGATES ACTION—Adopted the report of the Rural Health Committee as recommended by the Reference Committee on motion duly made and seconded.

Blood Banks

LESTER FORBES, M.D., *Chairman*

The need for widespread and uniform blood banking in the State of Georgia has been recognized for several years. Early in 1958, R. C. Williams of the State Public Health Department, called together a group of individuals interested in blood banking. As a result of this meeting, a committee was appointed to study and make recommendations as to a solution for blood banking in the State of Georgia. This committee gave its report in January of 1960.

The above mentioned group met and advised that a council be formed from the MAG, Georgia State Public Health, the Georgia Hospital Association, and the Red Cross. The purpose of this council was:

1. To organize and extend throughout the state a code of uniform blood banking.
2. The establishment of a system by which all hospitals might avail themselves of the entire state as a source of blood.

That this committee adopt and set forth uniform standards of blood banking; that it set into motion an educational program by which this information may be carried to all communities and hospitals; that it study the organization of the Florida Association of Blood Banks and its relationship to the Southeastern Clearing House of the American Association of Blood Banks in Jacksonville, and if so desired, pattern its plans after this organization.

Below listed is an outline of a plan that would seem feasible if adopted by this council.

In 1955, a minimum standards for blood banking was adopted by the House of Delegates of the MAG. This, with very little alteration and some adaptation as to size and scope of individual blood banks, could be used as a basis for minimum standards of blood banking in Georgia. Hospitals should be invited on a voluntary basis to acquaint themselves with this minimum standard and should be asked to meet these standards if possible. These standards could be used in an accreditation program such as is being put forth to hospitals now by the MAG, Georgia Hospital Association, and the Public Health in their hospital accreditation program.

As a secondary phase of this program, certain larger

hospitals located in strategic cities should be designated as reference blood banks. A good quality of blood banking already exists in most of the hospitals that would be selected. These larger community hospitals would be asked again, on a voluntary basis, to serve as centers to which the smaller communities could refer for aid in providing rare types of blood and solving problems in typing and crossmatching, and to provide blood in times of short supply. These hospitals should also act as training centers for personnel of smaller hospitals who are referred to these larger centers for more specific training and aid in blood banking.

These larger community hospitals should have a means of communication with one another and a centrally located office. This centrally located office might well be located in the MAG Headquarters. It need not have any blood banking facilities, but simply act as a coordinating center to transfer information concerning availability of blood, special types of blood and blood credits from one reference bank to another. One or more of the larger community banks must be selected as a bank which would have National Institute of Health licensure. This bank or banks would be used for communication with the rest of the country and interstate shipment of blood and credits of blood so that a patient in Georgia might avail himself of the American Association of Blood Banks clearing house program, which extends throughout the country. A uniform code of charges for blood and processing of blood must be adopted so that blood credits and blood may be shipped throughout the state and over state lines. The code should be adopted according to that recommended by the American Association of Blood Banks through its clearing house program with its Southeastern District located in Jacksonville. The details of this system provide a fair and equitable exchange of blood with fair and equitable charges for the member banks.

This system of blood exchange can be made self-supporting. A charge is made both to the recipient of blood or credits for blood and of the sender of blood or credits of blood. This charge is made by the central office and the funds are used to defray charges for personnel and for the continued coordination of the program.

An alternate program is possible. The Southeastern Headquarters of the American Association of Blood Banks clearing house program is located in Jacksonville. If each of the larger community blood banks were to become NIH licensed, then the program could be carried out directly with the Jacksonville headquarters with no central headquarters in the State of Georgia. This latter program may be advisable as there is already an established program in Florida and throughout the Southeast.

The persons representing the MAG on the Council should consist of people interested in blood banking. There should be at least one pathologist, and a representative from the Georgia Society of Medical Technologists, who is also interested in blood banking. This program will take the cooperation of the Georgia Association of Pathologists and all its members and will be greatly aided by the technical assistance of the Georgia Society of Medical Technologists and all its members.

Certain financial support will be necessary for the forwarding of this program. This money should be made available on a pro rata share by each of the three major organizations. If this is not agreeable with the

other organizations, the MAG should support it alone.

This committee also should concern itself with the dissemination of knowledge of blood banking throughout the state. There already exists in the Georgia State Public Health a division of hospital service. This group has been interested in holding workshops in various techniques of medical technology throughout the state. Its emphasis upon blood banking techniques for a short period of time would aid greatly in the forwarding of this information.

Only through a coordinated effort of the Georgia Hospital Association and the MAG and the Georgia State Public Health can a widespread, ample program of blood banking be established in Georgia.

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 1 approves the recommendations of this Committee that a council be formed from the MAG, the Georgia State Public Health Association, the Georgia State Hospital Association, and Red Cross for the purpose of organizing and extending throughout the state a code of uniform blood banking and establishing a system by which all hospitals might avail themselves of the entire state as a source of blood.

HOUSE OF DELEGATES ACTION—Adopted the report of the Blood Bank Committee as recommended by the Reference Committee on motion duly made and seconded.

Radiologic Safety

ROBERT M. TANKESLEY, M.D., *Chairman*

The Special Committee on Radiological Safety was formed to act as liaison to the State of Georgia, Department of Public Health to aid and advise in formulating policies on radiological safety. To date, this Committee has not been called upon and has no function to report for the past year.

REFERENCE COMMITTEE RECOMMENDATION—Report received as information.

HOUSE OF DELEGATES ACTION—Received the report of the Radiologic Safety Committee for information as recommended by the Reference Committee on motion duly made and seconded.

Headquarters Office

MR. M. D. KRUEGER, *Executive Secretary*
and

MR. JOHN F. KISER, *Associate Executive Secretary*

It is our belief that the Association Headquarters Office is the administrative "nerve center" of the MAG. The policies and plans of the Association as promulgated by the House of Delegates, the Council and its Executive Committee, the MAG Officers and Committee Chairmen can only be effective with accurate, efficient and knowledgeable administration by the Headquarters Office staff. It is toward this end that the personnel of the Headquarters Office are dedicated. This report will serve as a brief summary of the status and activity of the MAG Headquarters Office.

Personnel

As the Association continues to expand in membership and scope of activities, the administrative workload increases proportionately. Realizing this problem, the Executive Committee in 1958 authorized the employment of an administrative assistant to work with the Executive Secretary and the Associate Executive Secretary. Other staff positions have remained un-

changed, namely: bookkeeper handling accounts and membership; *Journal* managing editor, working under the direction of the *JMAG* editor; two general secretaries and the Medicare department with its administrator, assistant administrator, and a part-time typist. It should be cited that despite the increased activity, the number of staff personnel employed by the Association was not increased during the year 1959-60—and yet the administrative load was believed to have been adequately handled.

Facilities

It is appropriate to express the appreciation of the entire Headquarters Office staff for the facilities of the new MAG Headquarters Office building. A great deal of foresight and planning by the MAG Building Committee and the Council made this new office site a reality. The Headquarters Office staff takes pride in their part of this Association progress. With these new facilities, there will be an increased efficiency of operation and usage of the Headquarters Office facilities by the profession in Georgia.

Office Management

To fulfill the function of the Headquarters Office in the most effective methods and procedure, certain changes in "office systems" have been incorporated. The Council authorized an Office Management Study and the resultant recommendations from the firm conducting the study have been put in practice. Clear lines of office authority and responsibility are being established and a job analysis for each employee is also in preparation.

In the interests of better management, it is vital during the period of expanding activity to lay a solid foundation of common office procedures and systems. The responsibility of building maintainence is a new adjunct of administrative duty and will be assigned as staff function. Certain office equipment to allow for more "automation" will be recommended to Council for their consideration during the next year. The Council and its Executive Committee are to be commended for their interest and advice in all office management matters.

Future Plans

The Executive Secretary and Associate Executive Secretary are in accord in recommending for consideration that renewed emphasis be given to "charting the course" of the Association with a master outline covering three phases, namely: the immediate future; the short-range outlook covering the next few years; and a long-term view of the next 10 years. To this end, the Executive Committee of Council has scheduled a summer meeting to project "the big picture" of "what is the Association doing now—what is the Association contemplating for the next few years—and what are its long-range goals?" Also authorized for a summer meeting is a session of the six county medical society executive secretaries and the MAG Headquarters office staff to consider closer administrative liaison between the state medical association and its larger component county societies.

It is this type of planning by the MAG policy bodies that will make headquarters office administration function even more effectively. Messrs. Krueger and Kiser, in summary, express their sincere appreciation to the many physicians who have worked "for and with" their

Association in furthering the ideals and objectives of MAG—and also appreciation to the truly dedicated fellow-employees in the Headquarters Office who have served unstintingly at all times.

REFERENCE COMMITTEE RECOMMENDATION—Mr. Krueger, Mr. Kiser, and the entire office staff are to be highly commended for their work in behalf of MAG. We feel that the smooth operation of the MAG is due in large part to their efforts. The plans for the future of MAG are excellent and should be carried out with all possible dispatch.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Headquarters Office as recommended by the Reference Committee on motion duly made and seconded.

It was moved by the Chairman of Reference Committee No. 1, Leo Smith, Waycross, and duly seconded that the report of Reference Committee No. 1 be accepted as a whole and it was so ordered.

Report of Reference Committee No. 2

T. A. Sappington, M.D., Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendations and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 2 met at 8:00 A. M. in Room 630, Ralston Hotel, Columbus. The following members were present: T. A. Sappington, Thomaston, Chairman; H. E. Weems, Perry, Secretary; James Martin, Edison; Linton Bishop, Atlanta; W. L. Pomeroy, Waycross; C. J. Roper, Jasper; J. B. Traylor, Athens; M. E. Smith, Milledgeville, and F. N. Harrison, Augusta.

Secretary

CHRIS J. McLOUGHLIN, M.D., Atlanta

The office of the Secretary of your Medical Association has been a very busy one for the past several years and certainly the last 12 months have proved to be no exception. Your Association is growing in numbers and activities. There has been a tremendous increase in both the volume and importance of the medical organizational work, and it seems as though these problems will continue to increase and become even more complicated as time goes on. Ten years ago the Headquarters Office was run by one physician and a secretary-bookkeeper. Now your Association is housed in a building which will compare favorably with that of any medical association in the country. An Executive Secretary, an Assistant Executive Secretary plus many other helpers co-ordinate and carry out the work of the Association as directed by your House of Delegates, Council, the Executive Committee and your officers. The number of your committees is increasing, and the work of these committees is more widespread than ever. Many committees, however, still need interested members who are willing to work, and everyone is urged to take an active part in the affairs of the Association.

Membership		
	1959	1958
Active (Dues Paying)	2,477	2,410
Active (Dues Exempt)	338	347
Associate	17	18
Honorary	0	0
Service	55	39
	<hr/> 2,887	<hr/> 2,814

Medicare

At the height of the Medicare Program, approximately 2500 claims per month were processed in the Headquarters Office. When appropriations were cut, the number of claims decreased by 60 per cent. During the past year, a great deal of this cut-back was restored, and now the number of claims is increasing steadily until it amounts to more than 1200 per month at the present time. It is estimated that during the coming year Medicare costs will continue to rise even though some restrictions have been placed upon the nature of services to be rendered. It still seems advisable for your Medical Association to retain administrative control of the Medicare Program in Georgia. In February when the Medicare contract was renewed, your Council approved this wholeheartedly.

During the past year, we were forced to part company with Mr. John Arndt who had charge of the Medicare Department for us for the past two and one half years. His administrative abilities were excellent, and it is with regret that we see him leave. He is moving onward to greater heights, and we wish him good luck and offer him many thanks for a job well done.

Committee Activities

Many more committees than before have been active during the past year and it would be difficult to pick out which has meant the most, directly or indirectly, to the Association. Certainly your Committee on Insurance has worked steadily to provide us with many coverages which can be obtained for less than the average premium. The Public Relations Committee with its program for presidents and secretaries has helped medical organizations throughout the state considerably. The Distinguished Service Award Committee has provided a suitable medal to be awarded annually to the physician deemed to have rendered outstanding service to the Association. This service need not have been rendered during the past year, but at any time during a lifetime. We are greatly indebted to the Woman's Auxiliary for their cooperation and able help throughout the year. The Interprofessional Council has smoothed the road to peace and unanimity with the druggists and dentists. The Legislation Committee, under the leadership of Dr. J. Frank Walker and Dr. Eustace Allen, have made great contributions to better understanding between doctors and politicians on both state and national levels. Their work has been outstanding and is well worthy of commendation.

During the past year there has been much closer liaison between the podiatrists and the Medical Association. Your Council as well as the American Medical Association has recognized that podiatrists are not cultists, but are a group of well trained individuals whose help can be a great asset in the practice of

medicine. It is recommended that further cooperation should be encouraged.

It would seem that your Legal Counsel, as represented by Mr. Frank Shackelford and Mr. John Moore, have been most helpful and cooperative in meeting with us on many occasions and have rendered outstanding service.

In comparing Workman's Compensation Fees for the State of Georgia with those of other states, I find that these fees are greatly inferior to the charges in the other states and would, therefore, recommend that the fees again be scrutinized with the idea of renegotiating for a better schedule. Many of the doctors have complained about the present fee schedule.

In Chaptel II, Section 2, it states that ". . . The program for the general meeting shall be prepared by the Council of the Medical Association of Georgia and approved by Council at least 60 days before the annual session of the Association and published in an issue of the Journal preceding the annual session." As it is almost impossible to complete the program 60 days in advance and as Council usually does not have an opportunity to meet and review the program, it is suggested that the 60 day period be changed to 30 days in order that we may comply more fully with the Bylaws.

As many of our committees are only partially active, it is suggested that our Vice Presidents be placed in charge of coordinating these committees, and that a study of our committees should be made with the idea of reorganization of some and the abolition of others.

Before moving into our new building, it was felt that some reorganization of the Headquarters Office should be done. The firm of Shaw-Walker, who specializes in this work, was contacted and for the past several months, has been going over our records and filing systems. They assisted in the planning of changes in the new building, having in mind alterations which would help to improve efficiency, and I feel they are rendering us an excellent service. Almost all new equipment was purchased for the new building. Equipment which we possessed and which was not too antiquated was brought over and put to use, however. In order to expand our facilities properly, it was necessary to obtain a great deal more equipment.

The past year has found us a home of which we can be justly proud. It is hoped that the members will make use of it and its advantages in every way possible. It is nice to feel that we now have a home. It is nice to feel that we belong, and it is nice to know that our home compares most favorably with the association buildings throughout the nation. It is with pride that we can say that this home has come to us without the need for any supplemental assessments upon the membership. Looking back upon it, it has been a good and fruitful year. I wish to express my sincere thanks and appreciation to all who have contributed to the success of the Association. I wish to express my appreciation also to the very efficient executive staff headed by Mr. Milton Krueger and including each and every member on the staff.

REFERENCE COMMITTEE RECOMMENDATION—This report is accepted and endorsed with the following recommended changes. We suggest that the Secretary's recommendation, that the Workmen's Compensation Fee Schedule be revised, be immediately referred to the proper Standing Committee of the MAG for action. The Secretary's recommendation on changing the Constitution and

Bylaws to allow Council to approve the program of the Annual Meeting of MAG 30 days instead of 60 days in advance of the meeting should be referred to the Committee on Constitution and Bylaws for approval. We strongly recommend that the problem of reorganization of Standing Committees of MAG be immediately considered and action taken by Council. We recommend that the paragraph concerning padiatrists be changed to read as follows:

"During the past year there has been much closer liaison between the padiatrists and the Medical Association. Your Council as well as the AMA has recognized that padiatrists are not cultists. It is recommended that further cooperation should be encouraged."

It is readily apparent to this Committee that our Secretary and his staff have worked long, hard, and well during the past year and we wish to heartily commend them for a job well done.

HOUSE OF DELEGATES ACTION—Adapted the report of the Secretary as amended by the Reference Committee on motion duly made and seconded.

Treasurer

C. RAYMOND ARP, M.D., Atlanta

The auditors of the Medical Association of Georgia, Ernst and Ernst of Atlanta, have prepared an audit and the report for the calendar year ending December 31, 1959, is attached.

It is a pleasure to note that the income has increased over the last year and even though expenses have increased, the new income is greater this year than last year. With increased activity of the various committees and functions of our organization, we will have to expect increases in expenses.

It is also gratifying to note that the excess of assets over liabilities by funds shows a very good increase over last year. The importance of the committees of your organization and their activities cannot be over

emphasized. Actually they must have adequate funds on which to operate.

Each year the finance committee of the Council sets up a budget and proportions money according to the various needs of the Association. This budget has been approved by Council and at no time can or will money be spent without the full approval of Council. Expenditures are carefully checked by the auditors.

I would like to thank our very efficient bookkeeper, Miss Thelma Franklin, for myself and for the Medical Association of Georgia, for the manner in which she has taken care of the financial affairs this past year.

ERNST & ERNST
FIRST NATIONAL BANK BUILDING
ATLANTA 3, GA.

ACCOUNTANTS AUDITORS
MANAGEMENT SERVICES

OFFICES IN PRINCIPAL CITIES
ASSOCIATES IN FOREIGN COUNTRIES

Chairman of the Council
The Medical Association of Georgia
Atlanta, Georgia

We have examined the financial statements of The Medical Association of Georgia as of and for the year ended December 31, 1959. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets and liabilities - by funds and the statements of excess of assets over liabilities and of income and expense present fairly the financial position of The Medical Association of Georgia at December 31, 1959, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Ernst & Ernst

Certified Public Accountants

Atlanta, Georgia
February 6, 1960

STATEMENT OF ASSETS AND LIABILITIES — BY FUNDS
The Medical Association of Georgia
December 31, 1959

	General Fund	Department of the Army— Medicare Fund	Building Fund	Abner W. Calhaun Lectureship Fund	Combined
ASSETS					
Cash	\$ 435.74	\$40,614.08	\$ -0-	\$ 163.21	\$ 41,213.03
Marketable securities:					
United States government securities—at cost or redemption prices (quoted redemption prices \$12,440.00)	\$ -0-	\$ -0-	\$ 12,560.00	\$ -0-	\$ 12,560.00
Corporation stocks—at cost (quoted market prices \$5,229.00)	-0-	-0-	-0-	6,101.85	6,101.85
	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$ 12,560.00</u>	<u>\$ 6,101.85</u>	<u>\$ 18,661.85</u>
Accounts receivable:					
Due from United States government:					
Service fees paid to physicians and dentists	\$ -0-	\$44,385.92	\$ -0-	\$ -0-	\$ 44,385.92
December, 1959, provisional claim fees	674.80	-0-	-0-	-0-	674.80
Excess of claim expenses over provisional claim fees (\$8,090.60) received	4,222.45	-0-	-0-	-0-	4,222.45
Advertisers of The Journal and sundry other accounts	5,361.37	-0-	-0-	-0-	5,361.37
Due from Building Fund to General Fund	162.00	-0-	162.00*	-0-	-0-
	<u>\$10,420.62</u>	<u>\$44,385.92</u>	<u>\$ 162.00*</u>	<u>\$ -0-</u>	<u>\$ 54,644.54</u>
Property and equipment—on the basis of cost:					
Land—mortgaged	\$ -0-	\$ -0-	\$ 80,000.00	\$ -0-	\$ 80,000.00

STATEMENTS OF ASSETS AND LIABILITIES — BY FUNDS (continued)

	General Fund	Department of the Army— Medicare Fund	Building Fund	Abner W. Calhoun Lectureship Fund	Combined
ASSETS (continued)					
Building—mortgaged	-0-	-0-	105,900.00	-0-	105,900.00
Office furniture and equipment	15,603.69	-0-	-0-	-0-	15,603.69
Less* allowances for depreciation	6,796.33*	-0-	-0-	-0-	6,796.33*
	<u>\$ 8,807.36</u>	<u>\$ -0-</u>	<u>\$185,900.00</u>	<u>\$ -0-</u>	<u>\$194,707.36</u>
Prepaid expenses of 1960 annual meeting	1,655.47	-0-	-0-	-0-	1,655.47
	<u>\$21,319.19</u>	<u>\$85,000.00</u>	<u>\$198,298.00</u>	<u>\$ 6,265.06</u>	<u>\$310,882.25</u>
LIABILITIES					
Accounts payable and sundry liabilities	\$ 1,319.19	\$ -0-	\$ -0-	\$ -0-	\$ 1,319.19
Advance from United States government	-0-	85,000.00	-0-	-0-	85,000.00
Note payable to insurance company, payable \$4,000.000 annually beginning January 1, 1961, with interest at 5%—secured by loan deed on land and building	-0-	-0-	40,000.00	-0-	40,000.00
	<u>\$ 1,319.19</u>	<u>\$85,000.00</u>	<u>\$ 40,000.00</u>	<u>\$ -0-</u>	<u>\$126,319.19</u>
EXCESS OF ASSETS OVER LIABILITIES					
Balance at December 31, 1959	20,000.00	-0-	158,298.00	6,265.06	184,563.06
	<u>\$21,319.19</u>	<u>\$85,000.00</u>	<u>\$198,298.00</u>	<u>\$ 6,265.06</u>	<u>\$310,882.25</u>
Balance at January 1, 1959	\$20,000.00	\$ -0-	\$116,585.46	\$ 6,244.36	\$142,829.82
Income for the year in excess of expenses	41,464.54	-0-	248.00	20.70	41,733.24
	<u>\$61,464.54</u>	<u>\$ -0-</u>	<u>\$116,833.46</u>	<u>\$ 6,265.06</u>	<u>\$184,563.06</u>
Add—deduct* amount transferred from General Fund to Building Fund	41,464.54*	-0-	41,464.54	-0-	-0-
Balance at December 31, 1959	<u>\$20,000.00</u>	<u>\$ -0-</u>	<u>\$158,298.00</u>	<u>\$ 6,265.06</u>	<u>\$184,563.06</u>

STATEMENT OF INCOME AND EXPENSE — BY FUNDS
The Medical Association of Georgia
Year ended December 31, 1959

	General Fund	Building Fund	Abner W. Calhoun Lectureship Fund	Combined
INCOME				
Membership dues:				
Year 1959	\$ 98,320.00	\$ -0-	\$ -0-	\$ 98,320.00
Prior years	782.50	-0-	-0-	782.50
Less* allocation to subscriptions to The Journal	12,290.00*	-0-	-0-	12,290.00*
	<u>\$ 86,812.50</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$ 86,812.50</u>
Net income from The Journal	9,901.06	-0-	-0-	9,901.06
Interest income:				
United States government securities—				
Note A	937.50	-0-	-0-	937.50
Increase in redemption value—				
United States government securities	-0-	248.00	-0-	248.00
Savings deposits	3,422.91	-0-	-0-	3,422.91
Dividends on corporate stocks	-0-	-0-	278.92	278.92
TOTAL INCOME	<u>\$101,073.97</u>	<u>\$ 248.00</u>	<u>\$ 278.92</u>	<u>\$101,600.89</u>
EXPENSES				
Salaries	\$ 28,108.67	\$ -0-	\$ -0-	\$ 28,108.67
Less allocation to The Journal	4,304.78	-0-	-0-	4,304.78
	<u>\$ 23,803.89</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$ 23,803.89</u>

Administrative and other expenses	34,829.55	-0-	-0-	34,829.55
Expenses of 1959 annual meeting less fees				
from exhibitors of \$8,925.00	1,411.46	-0-	-0-	1,411.46
Lecture expenses	-0-	-0-	244.65	244.65
Trustee's fee	-0-	-0-	13.57	13.57
Loss on sale of equipment	220.02	-0-	-0-	220.02
TOTAL EXPENSES	\$ 60,264.92	\$ -0-	\$ 258.22	\$ 60,523.14
	<u>\$ 40,809.05</u>	<u>\$ 248.00</u>	<u>\$ 20.70</u>	<u>\$ 41,077.75</u>

OTHER INCOME

Received from American Medical Association				
for services and miscellaneous items	655.49	-0-	-0-	655.49
INCOME IN EXCESS OF EXPENSES	<u>\$ 41,464.54</u>	<u>\$ 248.00</u>	<u>\$ 20.70</u>	<u>\$ 41,733.24</u>

Note A—On May 10, 1953, The Council authorized interest received on United States Bonds held in the Building Fund to be recorded in the General Fund.

REFERENCE COMMITTEE RECOMMENDATION—This report was accepted and recommended for approval.

HOUSE OF DELEGATES ACTION—Adopted the report of the Treasurer as recommended by the Reference Committee on motion duly made and seconded.

Speaker of the House of Delegates

THOMAS W. GOODWIN, M.D., Augusta

The Speaker of the House continues to be interested in the preservation of parliamentary order and he continues to feel concern over the lack of representation in the House of the smaller county medical societies.

REFERENCE COMMITTEE RECOMMENDATION—This report was accepted and recommended for approval with the following change: We suggest that the Speaker request the Secretary of MAG to inform all local societies as to the proper manner of qualifying a substitute delegate when the duly elected delegate or his alternate is unable to attend the meetings of the House of Delegates.

HOUSE OF DELEGATES ACTION—Adopted the report of the Speaker as amended by the Reference Committee on motion duly made and seconded.

Vice Speaker, House of Delegates

FRED H. SIMONTON, Chickamauga

During the past year I have attended most of the Council meetings of the Medical Association of Georgia with the purpose of familiarizing myself with the activities of the MAG.

Your speaker, Doctor Tom Goodwin, has fulfilled his duties extremely well, and I have not been requested to act in this capacity during this session.

REFERENCE COMMITTEE RECOMMENDATION—This report was accepted and recommended for approval.

HOUSE OF DELEGATES ACTION—Adopted the report of the Vice Speaker as recommended by the Reference Committee on motion duly made and seconded.

Crawford W. Long Memorial Committee

LESTER RUMBLE, JR., M.D., *Chairman*

A major problem has existed with the Crawford W. Long Memorial ever since its opening some two and a half years ago. This memorial, located very strategically in Jefferson, Georgia with the advent of new highways, is gradually becoming a frequently visited and well known landmark in the State of Georgia. The problem that has existed has been in the maintenance

of this museum which of necessity must stay open seven days a week for at least eight hours per day. Although the Medical Association of Georgia has contributed generously for the last two years, a recent reduction in our budget has made this problem more acute.

Your Committee has not been inactive in trying to enlist outside support for this project. Only recently we visited the Governor of Georgia who has made a tentative promise of support for this museum but the problem is still acute. Your committee would certainly welcome any help that can be given to the financial problems existing at the museum.

There is also a plan whereby the scope of this museum would be enlarged to include the whole aspect of "pain" and its relief in the practice of medicine. The cost of this project will be somewhere in the neighborhood of \$150,000.00 and again private individuals who control the monies of certain foundations have been contacted in an effort to interest them in starting this project. Here again, your ideas as to individuals who might be interested in partially or completely underwriting such a move would be sincerely appreciated.

If you have not visited this museum, please make it a point to do so the next time you pass near Jefferson, Georgia. The time spent there will be well worth your while and we feel that the more people, particularly doctors, who visit this museum, the greater will be the interest in presenting one of Georgia's greatest events to the nation and to the world.

REFERENCE COMMITTEE RECOMMENDATION—We accept this report for approval with the recommendation that the MAG continue to furnish that financial support which Council deems practical. This is in view of the fact that we feel that the association of MAG's name and support with this museum is good public relations.

HOUSE OF DELEGATES ACTION—J. G. McDaniel, Chairman of MAG Council, asked for clarification of the Reference Committee recommendation. The past activity of this committee and the Council action on Committee recommendations was reviewed and Lester Rumble, Chairman of the Committee, discussed the MAG past financial support of the museum and also related some of the future plans of the museum. After this discussion, the House adopted the report of the Crawford W. Long Committee as recommended by the Reference Committee on motion duly made and seconded.

Insurance and Economics

DAVID R. THOMAS, M.D., *Chairman*

This year has been another year of changes and de-

velopments in the over all coverage of insurance that means much to our profession. The Committee, with the able assistance of Mr. Milton Krueger, Mr. John Kiser, and the Headquarters staff, has handled such matters presented, as well as the routine work that has been continued. The services of our legal counsels, Mr. Frank Shackelford and Mr. John Moore, have proven invaluable and their assistance is gratefully acknowledged.

John Elliott, with the assistance of Mr. H. B. Coolidge has continued to handle the settlement of unlisted procedures and to act as arbitrator in the claims with the Insurance Companies under the Georgia Plan. Their knowledge and unfailing service continues to be invaluable.

The organization of the "Health Care of the Aging" Committee, under the capable leadership of John Atwater, along the lines proposed by this committee last year, is most gratifying. This Committee has a tremendous task and it can be counted on for a job well done.

The change in our insurance company from the Provident Life and Accident Insurance Company to the Life Insurance Company of Georgia has caused considerable concern to many of the members of the MAG. This came about because the Provident Group Life Insurance was stagnating—and they proposed a new policy that would reduce the rates for the younger members and increase the rates for those of us in the older age group on a Group plan which is nothing but fair to all concerned. It was thought that by so doing, the number of participating physicians would be greatly increased. It was also proposed that the coverage be increased to \$10,000 and the age limit extended to the 75th birthday. Unfortunately, we could not get a satisfactory Group policy arranged with Provident and the Committee decided the change to Life of Georgia who made a more satisfactory agreement on a Group basis. The satisfactory service of Mr. LaFayette Davis as the Provident representative in Georgia is deeply appreciated by those of us who have known him through the years. He has met with and advised us on many matters that have come before this Committee and rendered a very valuable service. It is our opinion that he is an excellent insurance representative and was most unselfish with his time and talent in assisting us in every way that it was possible for him to serve the MAG.

The insurance carried by the members of MAG revealed that as of September 15th, 1959, we had a little more than 1,000 doctors covered in the three policies carried by us with the Provident Life and Accident Insurance Company. This is good insurance and although features needed improving, it was not subscribed to as fully as thought desirable. The premiums paid in have been tremendous through the years and the percentage of losses varied. The reserve accumulated by Provident are not known, but must have been considerable. We did not have a working agreement whereby that information was available to us.

In the change to the Life of Georgia, it is understood that we will have an annual audit of the experience of the policies written and from time to time, as is found necessary, the premiums might vary. The present thinking is that their experience in the Life, Accidental Death and Dismemberment, and the Health

and Accident policies, can be expected to reflect a reduction in premium or extended coverage. The experience with the Catastrophic Hospital and Nursing coverage was not as favorable with Provident and no estimate is available as to what our expense will be with Life of Georgia. As we see it, the overall policy of getting the best coverage for the majority of our members is the primary concern, with a premium that is equitable both to us and the Insurance Carrier. Changes have been made in our policies to improve them and further chance for improvement within the next year can be anticipated.

The coverage for widows and dependents of deceased members of MAG is being made available in the Catastrophic Hospital and Nursing Care policy. This will go into effect as soon after May 15th as a complete list is presented to Life of Georgia. The assistance of the Woman's Auxiliary is being sought in each component society in compiling such a list.

A retirement program for members of MAG is being studied and action is being deferred pending the outcome of the Smathers-Jenkins-Keogh bill now in Congress. It is conceivable that such a program might be very attractive to our membership.

Insurance Coverage for Physicians' Employees:

Proposals are being received and studied providing Group coverage that will be very attractive. It is realized that we are all in the market for good employees and we want to be able to help our employees obtain desirable insurance coverage at favorable rates. The results of this study will be published for your information and your cooperation solicited to enable us to put it into effect. If you have any feelings on this matter or suggestions that you might wish considered, please advise us. An overall policy of what will best serve your needs is our goal.

MAG Employees Insurance:

A program for these employees is being developed and will be put into effect.

Commercial Insurance Company of Newark, N. J. Health and Accident Insurance:

This is the oldest insurance program sponsored by MAG. It is an excellent program and is being expanded and improved to meet your needs for further coverage at favorable rates. This will be presented to you sometime after May 15th. Many of you already carry this Health and Accident policy.

The Georgia Plan:

This program is being continued and supported by members of the Insurance Industry. Coverage for the low income groups to take care of their cost of medical care remains one of our basic responsibilities. We must remember that low coverage is necessary for many people, particularly is this true because so many do not have the means to pay the higher premiums necessary for coverage that would provide for more than basic, necessary care. The best of medical care will be provided but not in hospital accommodations exceeding that which is necessary. It is our obligation and desire to see that the best professional care is available to those who need our service.

The cost of medical care is increasing as is everything else. The spiral is constantly up and up. We as

members of our noble profession must put a stop to unnecessary hospitalization and do everything within our power to prevent anything that encourages the socialization of our great country. Your help and mine is needed. What are we going to do about his vital issue? None of us want, nor can expect to get something for nothing. We all desire just compensation for our services rendered but our compensation many times cannot be measured in silver or gold. Often it is the satisfaction of having relieved suffering or saved a life, for what your patient is capable of paying, and at the same time preserving his feeling of self respect and not accepting charity or a dole from the Department of Public Welfare supported by his and our taxes.

REFERENCE COMMITTEE RECOMMENDATION—This report is accepted and recommended for approval. We would like to emphasize for information purposes that members of the MAG who so desire may continue their present coverage with the Provident Life and Accident Insurance Company on an individual basis. The Life Insurance Company of Georgia is now the carrier of the MAG Group Insurance Program. We wish to commend the Insurance Committee and feel sure that they will continue to work diligently for our insurance needs.

HOUSE OF DELEGATES ACTION—Adopted the report of the Insurance and Economics Committee as recommended by the Reference Committee on motion duly made and seconded.

Mental Health

R. J. VAN DE WETERING, *Chairman*

During the past year, the State of Georgia has made an excellent beginning in rectifying Georgia's archaic and inadequate approach to mental illness and its treatment. Steps have been taken to remedy some of the legal, educational, financial, and architectural handicaps which have for so many years prevented an adequate program in the State of Georgia. You are aware of most of these steps and I shall not enumerate them. Suffice it to say that members of the Medical Association of Georgia and its Mental Health Committee have been active in all of these programs and work. That which has been done, however, is only a beginning and the members of your Mental Health Committee have, and will be active in attempting to maintain momentum and interest in continuing this long-term job. To this end, the Mental Health Committee has, during the past year, concerned itself with a Mental Health Page in the *Journal of the Medical Association of Georgia* and has participated in beginning plans for a continuing program for psychiatric education for physicians.

The future efforts of your committee are consequently to be based along these two lines: (1) To continue the momentum and interest in State Mental Hospitals and Mental Hygiene Programs, and (2) In furthering the individual physician's and individual community's interest in the program. It is obvious that an improved State Hospital Program is only partially the answer to the mental health problems in Georgia. It is necessary that physicians reacquaint themselves with mental illness and their role in its treatment, and prevention. Thus, early case finding, and early treatment measures can be instituted. It is necessary too, that the community take an added responsibility and interest in developing means of putting community resources to work. One way that this can be accomplished is in the development of more psychiatric units in general hospitals. Recognizing that this is an excellent means

of education for both psychiatrists and general physicians, your committee is at present investigating hospitalization insurance plans in the hopes that psychiatric care can be added to these, and that this will in turn promote the development of psychiatric units in general hospitals. The committee also hopes to participate in an increasingly active educational project.

REFERENCE COMMITTEE RECOMMENDATION—We accept and recommend the adoption of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Mental Health Committee as recommended by the Reference Committee on motion duly made and seconded.

Supplementary Report on Mental Health No. A

COVERAGE OF MENTAL ILLNESS

R. J. VAN DE WETERING, M.D., *Chairman*

WHEREAS, great progress is being made in the field of mental health in Georgia, particularly in the development of a state program, and

WHEREAS, there is need for expansion of private facilities and programs for the treatment of the mentally ill, and

WHEREAS, many commercial insurance companies now provide coverage for outpatient and inpatient psychiatric care, and

WHEREAS, there is sound actuarial experience in other states indicating that mental illness can be covered in hospital and medical insurance policies without substantially increasing the cost of the premiums, and

WHEREAS, the Governor's Advisory Committee on Mental Institutions has recommended that action be taken to include coverage for psychiatric care in Blue Cross-Blue Shield policies.

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia strongly recommends the addition of coverage of mental illness in Blue Cross and Blue Shield policies on a regular basis for inpatient and outpatient care in both general and psychiatric hospitals.

AND BE IT FURTHER RESOLVED, that copies of this resolution be sent to the Columbus, Atlanta, and Savannah non-profit hospital and medical service plans.

REFERENCE COMMITTEE RECOMMENDATION—We recommend the adoption of this Resolution with the following change: The first resolved to read thusly:

"NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia recommends to the Blue Cross and Blue Shield Plans of this State that they study and consider the possibility of coverage of mental illness in their regular policies."

HOUSE OF DELEGATES ACTION—Adopted the Supplementary Report on Mental Health No. A: Coverage of Mental Illness as amended by the Reference Committee on motion duly made and seconded.

Scientific Exhibit Awards

TED F. LEIGH, M.D., *Chairman*

The Scientific Exhibits of the Annual Meeting of the Medical Association of Georgia in Augusta were prominently displayed in the Bon Air Hotel, in an area immediately off the main lobby of the hotel. The exhibits were of the highest caliber, and included displays not only by individual doctors and groups of doctors, but also organizations closely allied with medicine.

At the present writing, plans are well advanced for the Scientific Exhibits Section at the forthcoming meeting in Columbus. The space allotted to Scientific Exhibits will be about twice as large as that in Augusta. A particularly good response has come from physicians and organizations in Columbus. We believe that this year will be highly successful for our committee.

REFERENCE COMMITTEE RECOMMENDATION—We accept and recommend the adoption of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Scientific Exhibits and Awards Committee as recommended by the Reference Committee on motion duly made and seconded.

Crippled Children

J. C. HUGHSTON, M.D., *Chairman*

The forthcoming developments in crippled children's work in Georgia will be another state conference in Spring, 1961. This conference will be sponsored by the DuPont de Nemours Foundation with Doctor Al Shands of Wilmington, Delaware. The Columbus Chapter of the Junior League will coordinate the conference here. The purpose of the conference is to stimulate a unification of effort by the many societies and groups interested in the care of the Handicapped Child.

REFERENCE COMMITTEE RECOMMENDATION—We accept and recommend adoption of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Crippled Children's Committee as recommended by the Reference Committee on motion duly made and seconded.

Rehabilitation

ROBERT BENNETT, *Chairman*

The development of a committee on Rehabilitation was initiated by Dr. Wolff in June of 1959, following a recommendation of the AMA Committee on Rehabilitation encouraging state medical societies to set up committees on rehabilitation. The following members of the Medical Association of Georgia were appointed to this committee: Robert L. Bennett, Warm Springs, Chairman; James Funk, Atlanta; Jack Mohny, Augusta; Vernon Powell, Atlanta; Upton Clary, Savannah; Hal S. Raper, Warm Springs, and Mercer Blanchard, Columbus.

At its first meeting in November, the Committee formulated its initial objectives as follows:

1. To compile a list of state and local facilities in Georgia that provide rehabilitation services so that a Directory of these services within the state could be made available to the physicians of the state for their use.

2. To promote discussions of rehabilitation within existing medical programs throughout the state to further acquaint the physicians of Georgia with the field of rehabilitation.

3. To investigate applicable laws and legislation relating to the field of rehabilitation.

4. To establish liaison with para-medical groups and with governmental and other agencies working in the field of rehabilitation.

An attempt was made to determine the existence and function of similar committees in medical societies of other states. Thirty-three states replied to a submitted questionnaire and revealed that 16 had active commit-

tees on rehabilitation and that the remaining 17 had no committees on rehabilitation at that time. The composition and function of existing committees in the above 16 states replying to the questionnaire were outlined for the committee's use.

A second meeting of this Committee was held on March 5, 1960. Dr. Ralph De Forest, Secretary of the Committee on Rehabilitation of the American Medical Association, was present, and was of great value in assisting our Georgia committee formulate its more important activities. It was decided that the Committee's greatest emphasis during the company year would be on developing a handbook of rehabilitation facilities in the State of Georgia for distribution to all members of the Medical Association of Georgia. It was the opinion of the members of this Committee that many physicians in the State of Georgia, while appreciating the value of rehabilitation medicine, have limited knowledge of existing services and facilities that are available to their patients in the State of Georgia.

To be of greatest value to the physician, this handbook will not only list existing services and facilities but describe them in some detail, indicating the services that they offer and how these can be made available to the physician for his patient.

To gain the physician's attention regarding rehabilitation services and facilities in Georgia, an exhibit is planned for the 1961 meeting of the Medical Association of Georgia, at which time the Committee hopes that the handbook will be available for disbursement. It is also hoped that a discussion of rehabilitation and the facilities available to Georgia will be presented within the program of the Medical Association of Georgia in 1961.

Recommendations:

1. The name of the Committee on Rehabilitation be changed to the Committee on Physical Rehabilitation so that the scope of this Committee can be more clearly defined, and its responsibilities do not re-duplicate those of existing committees.

2. This Committee be made a standing committee of the Medical Association of Georgia with its members initially being appointed for periods of one, two, and three years. Initially, this could be done on an arbitrary alphabetical basis. Reappointments and new appointments would be for three year terms.

3. A sum of money, not to exceed \$500.00, be allocated to this committee for the preparation of a handbook on rehabilitation services and facilities in the State of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—We accept and recommend the adoption of this report with the following changes:

- (1) The second recommendation of this report is to await final action at the time of reorganization of the Standing Committees of the MAG.

- (2) The third recommendation we feel should be referred to the Council for their consideration and action.

HOUSE OF DELEGATES ACTION—Adopted the report of the Rehabilitation Committee as amended by the Reference Committee on motion duly made and seconded.

Journal of the Medical Association of Georgia

EDGAR WOODY, JR., M.D., *Editor*

The 1959-60 Report of the *Journal of the Medical*

Association of Georgia is submitted herewith:

Personnel: We are very pleased to announce that there have been no changes in the full time personnel employed by the *Journal* in the past year. Miss Anne G. Whiddon who became Managing Editor more than one year ago is continuing to function as our Managing Editor.

There has been one addition to our staff of contributing editors in the past year. He is Preston Ellington, a practicing pediatrician in Augusta, Georgia. Our other active contributing editors are Herbert S Alden, Atlanta; Thomas Findley, Augusta; J. Willis Hurst, Atlanta; Charles S. Jones, Atlanta; Arthur M. Knight, Waycross; Arthur J. Merrill, Atlanta; Lester Rumble, Jr., Atlanta; Peter L. Scardino, Savannah; Patrick C. Shea, Jr., Atlanta, and Robert H. Vaughan, Columbus. These editors have been very effective during the past year not only in their contribution of editorials but in their effective solicitation of desirable scientific papers for publication. Their consistent contributions to our feature page "Current Clinical Concepts" have made this page one of our more popular regular features.

Conferences: In September of 1959, the editor attended the Annual Meeting of the American Medical Writers' Association which was held in St. Louis. He serves on the Advisory Committee for this organization. In October of 1959, the Editor and Managing Editor attended the conference in Chicago sponsored by the State Medical Journal Advertising Bureau. These meetings are held every other year and have proven to be very valuable to all those attending. During this meeting, five state journals were given an award for general excellence. The *Journal of the Medical Association of Georgia* was honored to be among those receiving these awards.

Content: With an increased volume of advertising from national sources during the past 12 months, we have been fortunate to add two additional feature pages to the *Journal* to help maintain the balance between editorial copy and advertising. These new features are a Mental Health Page sponsored by the Committee on Mental Health and the Legal Page which is written by the legal counsel of the Medical Association of Georgia. It is felt that these new features fill a definite need in their respective areas and should help to sustain reader interest in the *Journal*.

The *Journal* continues to print an average of six scientific articles per month most of which are presented at the Annual Session. We have been fortunate during the past year to receive a considerable number of excellent scientific papers which have been solicited by our contributing editors.

The special feature pages, including the Heart Page, the President's Letter, the Cancer Page, and Current Clinical Concepts have been continued.

A feature in the form of an insert page, Top of the News, has continued to attract good readership by virtue of the freshness and timeliness of the news it presents and its easily readable and concise style.

With the continued flow of medical books into the *Journal* Office, the Physicians Bookshelf has remained a popular feature.

One of our oldest features, Abstracts by Georgia Authors, continues active. The continued publication of transcripts of Medical Grand Rounds from the Medical

College of Georgia and Emory University during the past year have added greatly to the desirable content of the *Journal*. Dr. Findley in Augusta has been particularly cooperative in supplying us with material frequently.

During the past 12 months two special issues have appeared, one devoted to the Milledgeville State Hospital in June, and one in January devoted to the mental health program throughout the state.

Format and Typography: During the past year increasing use has been made of the services of Mr. John S. McKenzie of the Higgins-McArthur Printing Company in the design of our *Journal* covers and general typography of the *Journal*. Ted F. Leigh has continued as an active member of our staff in his role as photography editor. On several occasions the photographic services of Mr. Joe Jackson of Emory University have been very helpful in the illustration of covers and feature material.

All type sizes have continued the same, with a few alterations each month for variety.

Mr. Milton Krueger and Mr. John Kiser have both been very helpful during the year in supplying news of the Association and its activities for the columns of the *Journal*.

During the year 1959-60, your *Journal* has experienced significant growth in the area of editorial copy as well as in advertising volume. From the editor's point of view it has been a very satisfactory year. It is hoped that our readers feel that progress has been made.

REFERENCE COMMITTEE RECOMMENDATION—We accept and recommend approval of this report. We would like to include a commendation to the *Journal* staff for the excellent job they have done in making our official publication one of pride to the entire membership of the Medical Association of Georgia.

HOUSE OF DELEGATES ACTION—Adopted the report of the MAG *Journal* as recommended by the Reference Committee on motion duly made and seconded.

It was moved by the Chairman of Reference Committee No. 2, T. A. Sappington, Thomaston, and duly seconded that the report of Reference Committee No. 2 be accepted as a whole and it was so ordered.

Report of Reference Committee No. 3

A. J. Waters, M.D., Chairman

(The following reports as presented to this reference committee are presented in full with the reference committee's recommendations and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 3 met at 8:00 A. M. on May 2, 1960, in Room 217, Ralston Hotel, Columbus, Georgia. Members present were: A. J. Waters, Augusta, Chairman; W. P. Stoner, Sylvester, Secretary; Charles McArthur, Cordele; Robert A. Pumpelly, Jesup; Bruce Burliegh, Marietta; Floyd Jarrell, Columbus; John P. Heard, Decatur, and Henry H. Tift, Macon.

AMA Delegates

C. H. RICHARDSON, SR., M.D., Macon; EUSTACE A. ALLEN, M.D., Atlanta; and HENRY H. TIFT, M.D., Macon

The House of Delegates of the American Medical Association held two meetings in 1959. One at the annual meeting of the Association, held in Atlantic City on June 7-12, and another in Dallas, Texas at the clinical meeting, held on December 1-4.

The major subjects which brought important policy action in Atlantic City were the report of the American Medical Association's Committee on Medical Care Plans, the relation between Medicine and Osteopathy, the report of the committee on preparation for General Practice, and the issue of Compulsory Social Security coverage.

The House of Delegates received Part I of the report of the Committee on Medical Care Plans as information only, and then acted upon the Commission's recommendations item by item. Thirty-six of these recommendations were accepted without change, but one of them; namely, B-4, was changed to read: "That study should be given to the removal of the requirement of hospital admission as the only condition under which payment of certain benefits will be made."

Item B-16 was emphasized by stating that the AMA believes that free choice of physician is the right of every individual, and one which he should be free to exercise, if he chooses.

The far reaching significance of recommendation of A-7 was emphasized, which says, "Free choice of physician is an important factor in the provision of good medical care, and also it emphasized that the medical profession should discharge more vigorously the self-imposed responsibility for assuring the competency of physicians services, and their provision at a cost which people can afford."

The House also strongly endorsed a recommendation B-11, which declared that "Those who received medical care benefits as a result of collective bargaining should have the widest possible choice from among Medical Care Plans for the provision of such care."

Medicine and Osteopathy

The House adopted the following policy statement regarding interprofessional relations:

"(A) All voluntary professional associations between doctors of medicine and those who practice a system of healing not based on scientific principles are unethical.

"(B) Enactment of medical practice acts requiring all who practice as physicians and surgeons to meet the same qualifications, take the same examinations, and graduate from schools approved by the same agency should be encouraged by the constituent associations.

"(C) It shall not be considered contrary to the Principles of Medical Ethics for doctors of medicine to teach students in an osteopathic college, which is in the process of being converted into an approved medical school under the supervision of the AMA Council on Medical Education and Hospitals.

"(D) A liaison committee be appointed by the Board of Trustees of the American Medical Association to meet with representatives of the American

Osteopathic Association to work out their common problems."

Preparation for General Practice

The House approved and commended the final report of the Committee on preparation for General Practice, which proposes a new two year internship program for graduates planning to become family physicians. The Committee felt that a one year internship encourages inadequate preparation for general practice. The suggested program includes a basic minimum of 18 months hospital training in medicine and pediatrics in a very broad sense, including care of the new born. A physician could then elect to spend the remaining six months for additional training in other segments of the program. However, those who plan to practice obstetrics would be expected to spend at least four months of the elective period in obstetrics.

Social Security

The House considered five resolutions on the subject of compulsory Social Security for self-employed physicians, and disapproved four which advocated compulsory inclusion of physicians.

The only one which was offered in opposition was the one which was presented by the Georgia Delegation, and this one was adopted.

The House also expressed concern over the possible effects that a change of policy might have on the Association's entire legislative program, particularly in respect to the Forand bill.

Another highlight of the meeting was the appearance of President Eisenhower, who addressed an overflowing audience of more than 5,000 at the Tuesday night inauguration of Dr. Louis M. Orr of Orlando, Florida, as President of the American Medical Association.

Dr. E. Vincent Askey of Los Angeles, Speaker of the House of Delegates, was named President-Elect for the coming year, and will succeed Dr. Orr as President at the Association's Annual meeting in June, 1960 at Miami Beach.

Freedom of choice of physician, relations between physicians and hospitals, a scholarship program for deserving medical students, and relative value studies of medical services were among the major subjects acted upon by the House of Delegates at the American Medical Association's Thirteenth Clinical Meeting held December 1-4 in Dallas.

Dr. Chesley W. Martin of Elgin, Oklahoma was named as the 1959 General Practitioner of the Year.

Two nationally known political leaders from Texas also addressed the Tuesday morning sessions, Senator Lyndon B. Johnson, majority leader of the U. S. Senate and Speaker of the U. S. House of Representatives, Sam Rayburn.

In considering four resolutions, which in various ways would have changed or replaced the statements on freedom of choice of physician, which the House adopted in June, 1959, when acting upon the recommendations in the report of the Commission on Medical Care Plans, the House reaffirmed the following two statements, approved in Atlantic City:

1. "The American Medical Association believes that free choice of physician is the right of every in-

dividual, and one which he should be free to exercise as he chooses.”

2. “Each individual should be accorded the privilege to select and change his physician at will or select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives.”

3. “Lest there be any misinterpretation, we state unequivocally, that the American Medical Association firmly subscribes to freedom of choice of physician, and free competition among physicians as being prerequisites to optimal medical care.”

Physician-Hospital Relations

The House received 12 resolutions on the subject of relationships between physicians and hospitals. To resolve any doubt about its position, the House did not act upon any of the resolutions, but instead reaffirmed the 1959 “Guides for Conduct of Physicians in Relationships with Institutions.”

These Guides summarize the following general principles as basic for adjusting controversies:

1. “A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.”

2. “Where a hospital is not selling the services of a physician, the financial arrangement, if any, between the hospital and the physician properly may be placed on any mutually satisfactory basis.”

3. “The practice of anesthesiology, pathology, physical medicine, and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine.”

Scholarship Program

To help meet the need for an increasing number of physicians in the future, the House approved the creation of a special study committee, which was to:

1. “Present a scholarship program, its development, administration, and the role of the American Medical Association in fulfilling it.

2. “Ascertain the maximum to which medical schools could expand their student bodies while maintaining the quality of medical education.

3. “Ascertain what universities can support new medical schools with qualified students and sufficient clinical material for teaching—either on a two year or a full four year basis.

4. “Investigate the securing of competent medical faculties.

5. “Investigate financing of expansion and establishment of medical schools.

6. “Investigate financing of medical education as to the most economical methods of obtaining high quality medical training.

7. “Develop methods of getting well-qualified students to undertake the study of medicine.

8. “Investigate the possibility of relaxing rigid geographic restrictions on the admission of students to medical schools.”

Relative Value Studies

Reaffirming a previous policy statement, the House

approved in principle the conducting of relative value studies by each state medical society, rather than a nationwide study or a series of regional studies by the AMA.

The House also:

Emphasized that local medical societies should insure that no member violate ethical traditions as they relate to ownership of pharmacies or stock in pharmaceutical companies.

Registered a strong protest to the Veterans Administration, urging stricter screening of non-service-connected disability patients admitted to government hospitals.

Reiterated the Association’s support of the Blue Shield concept and directed the Council on Medical Service to submit at the June, 1960 meeting its recommendations concerning a policy statement on AMA relationship with Blue Shield plans.

Urged that medical schools include in their curricula a course on the social, political, and economic aspects of medicine. Georgia introduced this resolution.

Called upon each individual physician to wage vigorous, dynamic, uncompromising fight against the Forand type of legislation.

At the Tuesday opening session, six state medical societies presented nearly \$250,000 to the American Medical Education Foundation. The checks turned over to Dr. George F. Lull, President of AMEF, were: California \$156,562; Indiana, \$35,570; New York, \$19,546; Utah, \$10,355; New Jersey, \$10,000, and Arizona, \$9,263.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the AMA Delegates and wishes to commend C. H. Richardson for his long and faithful service as delegate to AMA.

HOUSE OF DELEGATES ACTION—Adopted the report of the AMA Delegates as recommended by the Reference Committee on motion duly made and seconded.

Council of MAG

J. G. McDANIEL, *Chairman*

Gentlemen of the House of Delegates:

The Medical Association of Georgia has had an excellent year. The Councilors and Vice-Councilors have been most faithful in their attendance to the six Council meetings and 12 Executive Committee of Council meetings held from May 20, 1959 until April 30, 1960. At the May 20, 1959 organizational meeting of the Council, J. G. McDaniel, Atlanta, was elected Chairman of Council for 1959-60 and Charles Andrews, Canton, was elected Vice Chairman of Council. Edgar Woody, Jr., Atlanta, was reappointed Editor of the *Journal of the Medical Association of Georgia* for 1959-60. Virgil Williams, Griffin, was named Chairman of the Finance Committee and Raymond C. Arp, Atlanta, was named Treasurer of the Association. Mr. Milton D. Krueger was reappointed Executive Secretary for the year 1959-60.

As this was a most active year, your Chairman of Council wishes to highly commend the officers and members of Council for their untiring efforts during the past year. I wish to particularly note the cooperation Council has received, not only from the Council Committees, but from the Association Standing Com-

mittees and Special Committees. The Association President, Luther H. Wolff, Columbus, has made an outstanding contribution to the MAG during his term of office as President. His diligence and interest in all Association matters inspired other members of Council and committees to follow through with any duties assigned them. The President Elect, Milford B. Hatcher, Macon, has attended all meetings of the Council and its Executive Committee and has evidenced great potential as a leader of the profession for next year. The Immediate Past President, Lee Howard, Sr., Savannah, has maintained the same high degree of interest in Association affairs that he did during his term of office as President last year. The Association Secretary, Chris J. McLoughlin, Atlanta, has done an outstanding job this year and has spent many hours in hard work for the MAG. This was particularly true during the purchase and renovation of the new Headquarters Office building. He deserves our whole-hearted thanks. Raymond C. Arp, Atlanta, the Association Treasurer, has assumed the duties of this responsible office in a most efficient manner. Edgar Woody, Jr., Editor of the *Journal of the Medical Association of Georgia* continues his outstanding work on the *Journal*. The excellence of this publication reflects credit on the entire MAG membership.

The Chairman of Finance, Virgil Williams, has reported in detail the financial status of the MAG at all meetings. This committee is, of course, responsible for the preparation and the presentation of the annual budget which was approved by Council. These duties require considerable time, study, and effort. Dr. Williams is to be commended for a job well done. The Vice Chairman of Council, Charles Andrews, Canton, has attended all meetings of Council and has served extremely well in this capacity.

The Executive Secretary, Mr. Milton D. Krueger, and the Associate Executive Secretary, Mr. John F. Kiser, have functioned most efficiently and have worked long hours on behalf of the Association. Miss Thelma Franklin, in charge of bookkeeping and membership records, and the other members of the MAG staff, have contributed immeasurably to the success of the Headquarters Office. The entire Headquarters Office has taken in stride the extra work entailed in the purchase, moving, and renovation of the new Headquarters Office building. The Council regrets that Mr. John D. Arndt, who has done such an outstanding job for the Association as Medicare Administrator, has resigned to devote full time to the study of law. The Association wishes him Godspeed. Below is a resume of the highlights of the Council and Executive Committee meeting activities.

Council Committee on Health Care of Aging launched.

Special Committee on Rehabilitation appointed.

Active participation in Georgia Joint Council to Improve Health Care of Aging approved.

Voting time for election of MAG officers, etc., lengthened by one-day at MAG Annual Sessions.

Members of Woman's Auxiliary to MAG appointed in ex-officio capacity to MAG committees.

Council Building Committee studied and planned for new MAG Headquarters Office Building.

MAG New Member Indoctrination Luncheon Inaugurated.

New Group Policies for MAG members cover-

ing Term Life insurance, Health and Accident insurance and Hospital-Nurse Catastrophic insurance approved and made available.

Annual Session Lectureship "ground rules" clarified and written for addition to MAG Constitution and Bylaws.

State and National legislative activities planned and endorsed.

Participation in Governor's Commission on Aging endorsed.

Medicare contract renewed.

Headquarters Office "business procedures and systems study" authorized.

MAG members "Widows and Dependents" group coverage on Hospital-Nurse Catastrophic insurance approved.

MAG new Headquarters Office building, 938 Peachtree Street, N.E., Atlanta was purchased, renovated, office equipment installed, and an Association "Open House" in the new building authorized.

1960 MAG Budget approved.

Georgia Hospital-Medical Council accreditation program for smaller hospitals approved.

Memento of Appreciation to Fulton County Medical Society for providing MAG Headquarters Office space for many years approved.

MAG participation in Georgia Committee on Blood Bank Standardization approved.

Actions taken on resolutions opposing "Forand-type legislation" and "Inclusion of Physicians in Social Security (OASI).

Your Chairman of Council would like to suggest that after the new Headquarters Office building has been paid for in full, that we seriously consider setting aside any extra monies that we can accumulate through the years with the idea of carrying our own insurance for the MAG membership.

Below are listed the reports as submitted by the various MAG Council Committees:

FINANCE—Virgil Williams, M.D., *Chairman*

The following budget was approved by Council for 1960:

	1959 Budget	Income and Disbursements 10/30/59	Proposed Budget for 1960
INCOME			
Income from dues	\$ 95,000.00	\$ 98,142.50	\$ 98,500.00
Journal Advertising	45,000.00	36,805.55	47,000.00
Fees Exhibitors	8,750.00	8,750.00	8,400.00
Interest and AMA	2,600.00	3,120.02	500.00
GP	2,520.00	2,100.00	2,820.00
	\$153,870.00	\$148,918.07	\$157,220.00
DISBURSEMENTS			
1. Salaries	\$ 27,910.00	\$ 23,149.93	\$ 28,780.00
Bonus	1,542.50	—	1,557.50
GP	2,520.00	2,100.00	2,820.00
	\$ 31,972.50	\$ 25,249.93	\$ 33,157.50
2. Fixed Allotments			
Pension Payments	\$ 1,200.00	\$ 450.00	\$ 1,200.00
Honorarium	1,000.00	1,000.00	1,000.00
Atty. Retainer	1,200.00	1,200.00	2,400.00
Special Atty. Exp.	1,000.00	—	500.00
Annual Audit	500.00	509.34	500.00
Cont. F.C.M.S.	1,500.00	1,500.00	200.00
Insur. & Bonds Pers.	1,000.00	879.75	1,250.00
Woman's Auxiliary	1,500.00	1,500.00	1,500.00
	\$ 8,900.00	\$ 7,039.09	\$ 8,550.00

	1959 Budget	Income and Disbursements 10/30/59	Proposed Budget for 1960
3. Journal Publication			
Salaries	\$ 5,250.00	\$ 4,456.25	\$ 5,700.00
Bonus	575.00	—	662.50
Engraving & Cuts	1,500.00	1,111.49	1,800.00
Editorial Asst.	200.00	100.00	250.00
Stationery	400.00	632.22	500.00
Postage	650.00	500.00	700.00
Clipping Service	350.00	307.90	450.00
Add and Supplies	250.00	194.31	250.00
Copyright	50.00	48.00	50.00
Printing	35,000.00	30,911.14	38,000.00
Sales Tax	1,050.00	927.64	1,140.00
Sundry & Meetings	100.00	58.36	400.00
	<u>\$ 45,375.00</u>	<u>\$ 39,247.31</u>	<u>\$ 49,902.50</u>
4. Headquarters Expense			
Travel	\$ 4,000.00	\$ 1,220.94	\$ 4,000.00
AMA Travel,			
Del. Sec. Ex.	2,500.00	1,245.44	2,500.00
Meetings	750.00	450.95	750.00
Stat. Prtg. Supp.	1,800.00	1,180.95	1,800.00
Postage	1,800.00	1,886.58	2,000.00
Tel. & Tel.	\$ 2,500.00	\$ 2,398.63	\$ 2,800.00
Depreciation & Repl.	1,100.00	—	1,200.00
Service Office Maint.	500.00	426.05	750.00
Dues & Sub.	200.00	190.00	200.00
Janitor Serv. & Grat.	650.00	477.00	1,250.00
Payroll & Unemp. Tax	1,000.00	928.02	1,000.00
Sundry	450.00	150.10	450.00
Building Maint.			5,000.00
Bldg. Depre. &			
Major Repairs			1,500.00
Interest on Mort.			4,000.00
	<u>\$ 17,250.00</u>	<u>\$ 10,554.66</u>	<u>\$ 29,200.00</u>
5. Committee Expenses			
<i>Council Committees</i>			
1. Annual Session	\$ 10,681.00	\$ 9,868.11	\$ 11,000.00
1A. Ancillary Pers.	50.00	—	—
2. Dist Serv. Award	300.00	—	650.00
3. Headquarters			
Bldg.**	500.00	—	4,500.00
4. Health Care Aging		*	1,000.00
5. Med. School Courses	250.00	118.12	200.00
	<u>\$ 11,781.00</u>	<u>\$ 9,986.23</u>	<u>\$ 17,350.00</u>
<i>Standing Committees</i>			
6. Crawford W.			
Long	\$ 1,500.00	\$ 1,500.00	\$ 500.00
6A. Geriatrics	25.00	—	—
7. History &			
Vital Stat.	300.00	—	300.00
8. Hospital Rel.	500.00	132.93	1,000.00
9. Industrial Health	300.00	207.82	300.00
10. Ins. & Econ.	600.00	186.21	600.00
11. Legislation	2,400.00	2,361.16	2,810.00
12. Maternal Welfare	100.00	62.59	200.00
13. Medical Defense	3,500.00	1,234.38	2,000.00
14. Med. Education	250.00	183.65	150.00
15. Mental Health	250.00	160.91	250.00
16. Prof. Conduct	—	—	50.00
17. Public Service	1,000.00	1,116.72	1,800.00
18. Rural Health	1,005.00	999.24	500.00
19. Scientific Awards	100.00	109.13	100.00
19A. Veterans Affairs	150.00	—	—
	<u>\$ 11,980.00</u>	<u>\$ 8,254.74</u>	<u>\$ 10,560.00</u>
<i>Special Committees</i>			
20A. Blood Bank	\$ 750.00	\$ —	\$ —
20. Health Column	2,525.00	2,508.48	2,650.00
21. Med Civil Prep.	50.00	—	50.00
22. Ministerial			
Liaison	450.00	—	250.00
23. School Child			
Health	—	—	1,850.00
24. V.F.W. Liaison	—	—	50.00
	<u>\$ 3,745.00</u>	<u>\$ 2,508.48</u>	<u>\$ 4,850.00</u>
<i>Related Committees</i>			
25. AMA Del. Mtg.	\$ 500.00	\$ 27.00	\$ 1,000.00

26. Inter-Prof.			
Council	—	—	250.00
26A. M'ville Study Com.	—	*	—
27. Physician-Lawyer	250.00	—	250.00
28. SAMA	300.00	118.71	500.00
29. SMEB	100.00	50.00	100.00
	<u>\$ 1,150.00</u>	<u>\$ 195.71</u>	<u>\$ 2,100.00</u>
Building		\$ 10,000.00	
Equipment	\$ 750.00	\$ 750.00*	
Total Disbursements	\$132,903.50	\$113,786.15	\$155,670.00
Contingent	\$ 5,000.00		\$ 1,550.00
Expenses for Retainer		\$ 181.74	
Florida Medical Assoc.		500.00	
Nat'l. Conf. on			
Phys. & Sch.		154.31	
Attorney Retainer		1,200.00	
M'ville Study Com.		4,344.41	
Health Care of Aging		1,000.00	
Equipment		1,400.00	
		<u>\$ 8,780.46</u>	
Reserve Fund	\$ 15,966.50		
Bank Balance		\$ 47,087.82	
Savings & Building		\$ 80,000.00	
Bonds (Maturity 1960-1-2)		\$ 27,312.00	
*Additional expenses charged to Contingent			
**Moving and renovation			

COUNCILOR APPORTIONMENT AND REDISTRICTING—Thomas W. Goodwin, M.D., *Chairman*

This committee has not met within the last year since all of the recommendations which had been previously made by this committee were considered at the 1959 meeting of the House of Delegates in Augusta. Those recommendations which the House of Delegates approved have been written into the Constitution and Bylaws and are to come before the House for a second reading at the Annual Meeting in Columbus.

HEADQUARTERS BUILDING — Christopher J. McLoughlin, M.D., *Chairman*

February, 1960, saw the culmination of almost three years of intensive work in finding a home for the Medical Association of Georgia.

In 1942, there was some discussion regarding the purchase of a building to serve as Headquarters for the Medical Association of Georgia. At that time, a building fund was instituted for the idea of setting aside money each year to be used for this purpose. During the ensuing years, the question was brought up from time to time, but nothing very positive was done about it.

Nearly three years ago negotiations were discussed with a committee from the Fulton County Medical Society with the idea of leasing or purchasing a portion of the property behind the Academy of Medicine on West Peachtree Street. Unfortunately, the committee from the local society felt that it would not be to their advantage nor ours to have another building on their property. Consequently, it was necessary to search for another location.

For the last year, many locations were investigated, considered, and rejected. For quite some time, a building on Peachtree Street owned by the Gulf Life Insurance Company was considered. After investigation and comparing this building with other sites and buildings available, it was unanimously decided that this building was just what we needed. Negotiations were made with the Gulf Life Insurance Company for the purchase of this building, and after much discussion, a compromise was reached on the price.

Gulf Life Insurance Company moved out as of December 31, 1959. Immediately contractors began making changes within the building to accommodate it to our needs. By February these changes were completed and the staff moved from the Academy of Medicine to the new Medical Association of Georgia building without losing a day of work.

Your Council appropriated money for the purchase of new equipment and for the structural changes necessary, and we feel that we now have a building which will compare favorably with the home of any medical association in the country.

Your Medical Association is now housed in a two story building containing approximately 6400 square feet. It is air-conditioned. The lot on which the building stands fronts 80 feet on Peachtree Street and extends back 400 feet to Cypress Street. There is a driveway entrance on both streets. The parking lot is paved with parking spaces marked off for 50 cars. More parking space can be made available if needed.

One more remarkable point about your new Headquarters is that all of this has been accomplished without additional assessment. A non-official word from a member of the national headquarters stated that he felt this was the only building that had been purchased or built without an additional assessment.

Your Building Committee is, therefore, delighted to turn over to you this new home for the Medical Association of Georgia.

MEDICAL SCHOOL COURSE—Christopher J. McLoughlin, M.D., *Chairman*

Due to lack of interest plus a rather crowded schedule at both medical schools, the courses for senior students in "The Science of Medical Practice" were not given this year. These courses have been well received by the students during the past few years.

A panel on "Religion in Medicine" will be held at each school before the close of the semester. In conjunction with this panel, there will probably be a reception for students and their wives with a dinner to be sponsored by a pharmaceutical house.

It is hoped that arrangements can be made before the next school term begins for these courses to be made part of the curriculum at both schools.

CLARKSVILLE LABORATORY SCHOOL—Charles R. Andrews, Jr., M.D., *Chairman*

As Chairman of the Clarksville Lab School Committee, I wish to report no activity of this committee up to the present time as there has been no new information in change of activity with regard to the Laboratory School. It is our opinion that this committee should continue to exist as an observing or "watchdog" type committee to keep the Medical Association of Georgia informed as to the approach of the Lab School toward its training, ethics, and relationship with other laboratory teaching facilities.

ANNUAL SESSION—Henry H. Tift, M.D., *Chairman*

For the first time in the history of the Medical Association of Georgia, the Annual Session will be held in Columbus. The dates for the meeting are May 1st through May 4th, 1960. The members of the Muscogee County Medical Society and their Auxiliary have been most cooperative and enthusiastic in making preparations for the meeting.

I am greatly indebted again to Peter Hydrick, of College Park, who has arranged all of the commercial exhibits. Ted Leigh, of Emory University, has done an outstanding job as Chairman of Scientific Exhibits.

The program for the 1960 Annual Session is printed in a separate booklet for distribution to all members of the Medical Association of Georgia. This program represents the official report of the Committee.

The many details of the Annual Session were handled by Mr. Milton Krueger in his usual efficient manner.

This is my third consecutive year as Chairman of this Committee and I respectfully request the Council to appoint a new Committee Chairman for 1961. This request is made because I feel that new ideas are needed so that the Annual Session will not become stereotyped. One suggestion that was made to me that I would like to pass on to my successor is that of having short "refresher courses" on certain selected topics during the Annual Session. Another suggestion has been to have a "Medical Student Day," particularly when the meeting is in Atlanta or Augusta, with scientific and social activities planned for students.

I feel that the system of rotating the site of the Convention among various cities is very desirable and should be continued. In the future, it is hoped that other cities, such as Brunswick (Jekyll Island), will join the present group of host communities.

LECTURESHIP—George H. Alexander, M.D., *Chairman*

The Lectureship Committee of Council has held three meetings, the first being held on July 16, 1959, at the Headquarters Office, which meeting the Chairman, at the last minute was prevented from attending, but at which the other members were present along with David Henry Poer in an advisory capacity. At this meeting, tentative ground rules for lectureships were set up which later were approved by Council at its July meeting.

Later in the meeting, sponsors for proposed new lectureships were invited to present their proposals.

Murdock Equen was requested to submit his proposal for the Joint Equen Lectureship in concrete form in order that it might be submitted to Council for approval.

Dr. Poer discussed the plans of Floyd McRae for the McRae Lectureship and stated that he would discuss the ground rules with Dr. McRae in order that he might submit a proposal to Council.

A. H. Letton discussed a Cancer Lectureship and since it did not qualify under the ground rules, he was advised to contact the program chairman of the section programs concerning the programming of a Cancer Lectureship.

Following the July 25, 1959 Council meeting, the Chairman corresponded with Dr. McRae and Dr. Equen concerning the plans for the McRae and Equen Lectureships. Dr. McRae advised that he wished to withdraw the McRae Lectureship. Correspondence continued with Dr. Equen followed by a personal Conference the latter part of October which was followed by a letter from Dr. Equen under date of November 15, 1959 in which he withdrew the Equen Lectureship stating that he felt it would be rather "complicated on a State basis."

A later letter stated that he planned to set up a lectureship in bronchoscopy locally.

The second meeting of the committee was held at Headquarters Office on December 10, 1959 with a full attendance at which time all the activities were fully discussed and the following recommendations were made to Council:

1. That Ground Rules for the establishment of new lectureships had been recommended and adopted by Council and that these Ground Rules should form the framework for any future lectureships.

2. That the committee was informed at this meeting of the unfortunate death of Glenville Giddens who has been the representative of Dr. Calhoun for the Calhoun Lectureships. The committee accordingly wishes to suggest that Dr. Calhoun be requested to name someone else to act as his representative to Council.

3. It is recommended that any suggested speaker on a lectureship program be presented directly in the future to the Annual Session Chairman. If this is done, and since there is only one lectureship still in existence at the present time, it appears to the committee that the work for which the Lectureship Committee was appointed has been completed and that there probably is no further work for the committee to do. The discharge of this committee is therefore recommended.

Council at its December meeting continued the Lectureship Committee and instructed it to rough-draft an amendment to the Bylaws incorporating ground rules for lectureships.

The Committee again met at Headquarters Office on February 18, 1960 which meeting was attended by two of its three members. As instructed by Council, a proposal was drafted to amend Chapter II of the Bylaws to provide for the manner in which Lectureships should be set up and conducted. This proposed amendment will be submitted to the House of Delegates in the report of the Committee on Constitution and Bylaws.

The Chairman has in the committee file additional details and background information which will gladly be made available if needed.

HEALTH CARE OF THE AGING—John S. Atwater, M.D., *Chairman*

The decision of the Council and President of the Medical Association of Georgia to create a special committee on the Health Care of the Aging proved to be wise for no greater problem has confronted physicians and the practice of medicine in the past 25 years. By the same token, such has adversely affected not only the physician, but the health picture of our senior citizens themselves.

The work of the Health Care of the Aging Committee may be divided loosely into three phases, namely orientation, organization, and education.

ORIENTATION

The first, orientation, was provided through: (1) Attendance at three major meetings: The Insurance and Prepayment Plan Conference, Memphis, Tennessee; The National Joint Council to Improve the Health Care of the Aged, Washington, D. C., and The National Leadership Training Institute, Ann Arbor, Michigan; (2) A flood of mail information from the American Medical Association and governmental offices; and (3) The sharing of experiences and information with many vitally interested collateral groups, especially the following: The State Departments of Public Health, Labor, Welfare, Rehabilitation, Education and Agriculture; The

Georgia Mental Health Association; The Georgia Bankers Association; representatives of churches, insurance industry, Georgia Municipal Association, Association of County Commissioners, American Institute of Architects, Associated Industries of Georgia, Georgia Bar Association, as well as representatives from the various major purveyors of health.

ORGANIZATION

Early in the year it was expedient to organize the Georgia Joint Council to Improve the Health Care of the Aged. This group brought together, in an organized manner, the Dental, Hospital Nursing Homes, Homes for the Aged and medical representatives. The elected Chairman of this group has been the Chairman of the Medical Association's Committee on Health Care of the Aging. Splendid cooperation between all health purveyors has existed. The organization has received national recognition for its work and has served as a model for other states. The objectives of the Georgia Joint Council have been set forth in an editorial appearing in the *Journal of the Medical Association of Georgia*, Vol. 48, August, 1959.

The next organizational step was initiated through an interview with Governor Vandiver by representatives of the Medical Association of Georgia and the Georgia Joint Council to Improve the Health Care of the Aged. The results of this interview, leading to the establishment of the Governor's Commission on Aging, are recorded in another editorial in the *Journal of the Medical Association of Georgia*, Vol. 48, November, 1959.

Furthermore, John Mauldin, as Chairman of the Governor's Commission, was named a member of the Georgia Joint Council to Improve the Health Care of the Aged and the Georgia Dental Association. Dr. Ernest Mingledorff as Secretary of the Commission and John Atwater as Chairman of the Health Committee and the Governor's Conference, or the so called "Little White House Conference" to be held in Athens, Georgia during 1960. Through these various mechanisms, there has been afforded the chance of leadership in thinking and action consistent with the policies of the Medical Association of Georgia. In addition, your Chairman has addressed several district meetings with lay county committees on aging and has had a part in the questionnaire survey regarding the health needs and resources of the elder citizens of Georgia.

EDUCATION

The physicians of Georgia have been informed of the aging health problems through a media of official medical publications, television and radio interviews, press releases, and personal appearances of members of the committee. The Editor of the *Journal of the Medical Association of Georgia*, has been most cooperative in devoting two editorials to the work of this committee, as well as two covers related to aging, and numerous space filler aging comments.

In November of 1959 in conjunction with the Legislative and Public Service Committees, the Health Care of the Aging Committee sponsored a Medical-Legislative Conference in Atlanta. At this conference, county society representatives were alerted to the problems of aging in Georgia and in the nation. Suggestions were made regarding means of meeting the problems forceably at local levels with community and medical action. This conference was followed up by members of the

committee speaking at many local county medical societies and woman's auxiliaries. As a result and corollary of this, many other appearances were made before lay and para-medical groups.

In March, your committee cooperated with the American Medical Association in hosting a Southeastern Regional Conference on Aging. Approximately 400 representatives from all of the southeastern states and coming from all walks of life attended. The Conference was well received and was accredited with being one of the best of a series of similar meetings held throughout the United States.

Coincident to this conference, there was a meeting of the representatives of medical societies of the southeastern states. The plans and activities of each were reviewed. Comments from a member of the Board of Trustees of the American Medical Association were, in effect, that if other states could follow the pattern of Georgia, the problem of health care and legislative interference would be nearer a solution.

Since the various health surveys had not included the attitude of the physician himself toward health needs and resources, it was suggested to the Council of the Medical Association of Georgia, with approval, that a physicians survey questionnaire be activated. This is under active planning at this time. It should be released shortly.

At the request of the American Medical Association, your Chairman has been made a member of the National Speaker's Bureau. This group is composed of 20 members whose purpose is to augment speaking engagements for the President, President Elect, Officers, and members of the Board of Trustees of the American Medical Association. In accepting this assignment, your Chairman has done so on the basis of this being an integral part of his committee's sphere, specifically being the further education of the public and the profession regarding the attitudes and activities of organized medicine and its behalf.

Lastly, your Chairman will appear in the National Conference Preparatory to the White House Conference which has been called in the immediate future.

Needless to say, there have been many other facets to this year's work that are incidental to the above report, but too numerous to mention. The help and cooperation of committee members and the executive staff has been overwhelming. The President and the Council of the Medical Association of Georgia has never denied a request for support or advice in any matter pertinent to this committee. Speaking on behalf of the committee, we are deeply indebted for such a fine spirit.

RECOMMENDATIONS

On the basis of the work of the past year, it is recommended that:

- (1) A special committee on the Health Care of the Aging be continued.
- (2) That continued support be reaffirmed to the Georgia Joint Council to Improve the Health Care of the Aged.
- (3) That continued support be reaffirmed to the Governor's Commission on Aging.
- (4) That an appropriate token of appreciation be presented to Hon. S. Ernest Vandiver, Governor, State of Georgia, in recognition of his interest in the health problems of the aged.

- (5) That the Medical Association of Georgia reaffirm its position as being opposed to Forand or Forand-type legislation.
- (6) That the Medical Association of Georgia urge its members to fully support the physician's questionnaire.
- (7) That the Medical Association of Georgia urge its members to actively participate in and work with other members of their local county committees on aging.

Membership by Districts

Districts	Members December 31, 1959		Members December 31, 1958	
	MAG	AMA	MAG	AMA
First	215	190	210	184
Second	168	131	165	130
Third	195	178	199	177
Fourth	146	113	147	110
Fifth	998	809	957	775
Sixth	247	170	231	168
Seventh	261	216	254	208
Eighth	181	152	177	150
Ninth	146	119	148	114
Tenth	330	273	332	266
TOTAL	2887	2351	2814	2283

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of Council with the following change in the report (Page 39, Delegates Handbook): "For the first time in the history of the Medical Association of Georgia . . ." be changed to "For the first time since the 1922 Annual Meeting held in Columbus . . ." This Committee wishes to commend John S. Atwater and his committee on Aging as well as the Governor and his Commission for their work on the study of the aged and further recommends that a letter of appreciation be sent to Governor Vandiver by the Speaker of the House of Delegates.

HOUSE OF DELEGATES ACTION—Adopted the report of the Council as amended by the Reference Committee on motion duly made and seconded.

First District Councilor

CHARLES T. BROWN, M.D., Guyton

All meetings of the Council have been attended with the exception of one. The First District was represented on this occasion by Vice Councilor T. A. Peterson. One professional conduct complaint was submitted during the year and information concerning this complaint was sent to MAG President Luther Wolff for jurisdiction by MAG Professional Conduct Committee.

The First District Medical Society met in Statesboro on April 15, 1959 with a scientific program followed by a fellowship hour for members and wives. Your Councilor was privileged to meet with the Bulloch-Candler-Evans Medical Society in January, 1960. The meeting was well attended and members seemed enthusiastic. A social and scientific program was enjoyed with wives and visitors. The 18 counties comprising First District have eight component medical societies with a total of 204 members enrolled.

Counties and Secretaries	Members December 31, 1959		Members December 31, 1958	
	MAG	AMA	MAG	AMA
Bulloch-Candler-Evans				
Robert Swint, Metter	18	16	19	14

Burke				
B. Lamar Murray,				
Waynesboro . . .	8	6	8	6
Emanuel				
R. G. Brown,				
Swainsboro . . .	8	7	7	6
Georgia Medical Society				
Lawrence Salter,				
Savannah . . .	149	134	145	132
Jenkins				
A. P. Mulkey,				
Millen	3	3	3	3
Screven				
Gerald Hogsette,				
Sylvania	5	5	6	5
Southeast Georgia				
John McArthur,				
Lyons	22	18	20	16
Tri-Liberty-Long-McIntosh				
	2	1	2	2
	215	190	210	184

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the First District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the First District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Second District Councilor

GEORGE R. DILLINGER, M.D., Thomasville

There has been a slight gain in membership during the past year in total membership of the district.

Most of the medical societies are active and hold excellent clinical meetings.

I would like to bring to the attention of the District that in 1959 there were 37 members belonging to the County and State Association, who had no affiliation with the American Medical Association. Our representation in the American Medical Association depends upon the number of AMA members. I feel that every one should belong to the AMA and support their activities and programs. For their membership, even though they take no particular interest in the political and economic fields, a member of the AMA has available the AMA library. He receives the American Medical Association Journal, also for that membership a specialty journal.

Counties and Secretaries	Members December 31, 1959		Members December 31, 1958	
	MAG	AMA	MAG	AMA
Colquitt				
James Flynn, Moultrie	18	14	17	14
Decatur-Seminole				
M. A. Ehrlich,				
Bainbridge . . .	17	15	17	15
Dougherty				
R. D. Waller, Albany	46	30	43	29
Grady				
John Ferrence,				
Whigham . . .	4	4	5	4
Mitchell				
A. A. McNeill,				
Camilla	10	9	11	9
Southwest Georgia				
J. B. Martin, Edison	15	10	14	10

Thomas-Brooks				
Julian Neel,				
Thomasville . . .	37	31	37	32
Tift				
P. W. Lucas, Tifton	15	14	15	13
Worth				
H. G. Davis,				
Sylvester	6	4	6	4
	168	131	165	130

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Second District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Second District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Legislation

J. FRANK WALKER, M.D., *Chairman*

EUSTACE A. ALLEN, M.D., *Vice Chairman*

For the first time in many years your Committee on Legislation has been more concerned with national legislation than with matters in the state legislature. This, of course, was due to our study and activities in regard to the Forand bill.

A special meeting to consider the Forand bill was held in November for representatives of County Medical Societies. This meeting was well attended and the subject was covered well by speakers from the AMA Washington and Chicago offices and by Congressman Dale Alford, a physician of Little Rock, Arkansas. Preceding and following this Conference, all county medical societies were urged to call special meetings to consider the Forand bill and the health care of our aged population. A speakers bureau was established by MAG and a special film presentation by Dr. Louis Orr, President of the AMA, was offered to county societies. The speakers and the film were used extensively throughout the state.

In February, at the Annual County Society Officers Conference, Congressman Jack Flynt of Griffin spoke on the Forand bill. MAG distributed bulletins and special mailings and a number of articles, editorials, and news items were published in the *Journal*. The November cover of the *Journal* pictured the campaign kit of materials that was distributed to all county societies.

A most successful trip to Washington the last day of March resulted in increased good public relations with our Congressmen and Senators. Twelve physicians including President Luther Wolff made this trip and enjoyed hearing from the Georgia delegation in Washington at a luncheon in Speaker Rayburn's Dining Room at the Capitol.

Other National Legislation

Your Committee also worked hard on the Smathers-Keogh-Simpson Bill which would permit self-employed persons to set aside tax-exempt funds for retirement purposes. The Committee spent considerable time expressing the opinions of members of the Association in regard to expansion of the Social Security System to include physicians.

State Legislation

The 1960 session of the Georgia General Assembly was a very constructive one. The primary accomplishments included 10 mental health measures, a new insurance code, and a bill permitting the state to pay physicians for physical examination of applicants for employment with the state.

Probably the most important and the most controversial bill in the mental health group was the commitment bill which passed on the last day of the session despite efforts of a few legislators to have it killed. This bill modernizes and humanizes present commitment procedures, making them more medical and less legal. The big job is to get the Ordinaries in each County to use the new law rather than the old one.

Other new mental health laws provide for the addition of a psychiatrist to the State Board of Health, transfer of Gracewood and the Alcoholic Commission to the Department of Public Health, scholarships for professional personnel in the field of psychiatry, and continuation of a joint mental health study committee of the legislature.

The Committee would like to congratulate Governor Vandiver, the members of the Joint Legislative Committee on Mental Health, the members of the Governor's Advisory Committee on Mental Institutions, and the Georgia Department of Public Health for their leadership and diligence without which these laws would not have been enacted.

We were proud to participate in the development of this new mental health legislation as part of our role of guardians of Georgia's health. We were consulted numerous times during the session as to our views on mental health bills and other measures of medical and health interest. We feel that the Association is fulfilling its responsibility in this area by making available information and recommendations on health and medical matters.

Failing to become law was a bill to require the labeling of blood by race, a bill to establish an interim study committee to study osteopathy, and a bill to further clarify the law relating to tax exemption for property belonging to professional societies.

Advice from MAG legal counsel has been of invaluable assistance this year and greatly expedited the work of the committee. Every active member of the Association knows well how fortunate is this committee in having the services of John Kiser.

The Committee wishes to recommend the appointment of keymen on the county society level. At the present time we have district keymen working with our committee and this keyman system should be extended to include a physician appointed by each county medical society to work with the committee.

In conclusion, the Committee would like to assure all members of our continued interest in maintaining a positive legislative program each year as in the past. This will be done on both the national and state levels.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Legislation Committee and wishes to commend the Committee for a job well done.

HOUSE OF DELEGATES ACTION—Adopted the report of the Legislation Committee as recommended by the Reference Committee on motion duly made and seconded.

Professional Conduct

C. F. HOLTON, M.D., *Chairman*

My committee did not meet as a whole. There were two cases to be considered but one turned out to be from the First District and Dr. Howard and I were disqualified to sit on that case. I never did learn what was done about it.

The Griffin case was withdrawn by the plaintiff.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Professional Conduct Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Professional Conduct Committee as recommended by the Reference Committee on motion duly made and seconded.

Veterans' Affairs

LEE HOWARD, JR., M.D., *Chairman*

The committee held no meetings during the year. No problems relating to Veterans' Affairs were presented to the committee. A meeting was held in Macon during the year but this related only to procedures involving employees of the Veterans Administration and was not attended. The committee has no recommendations to make for the coming year.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Veterans Affairs Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Veterans Affairs Committee as recommended by the Reference Committee on motion duly made and seconded.

School Child Health

GRADY E. BLACK, M.D., *Chairman*

The School Child Health Committee of the Medical Association of Georgia has been very active in the past year. Several well attended meetings were held.

Among the projects that this committee has dealt are health safety and physical education, as well as accident prevention. A letter was sent by the Committee to all county medical societies asking the local physicians to make themselves available to talk on subjects pertaining to school health at local civic club meetings and at the schools.

In the area of driver training and school bus safety, the Committee offered to serve in an advisory capacity. This committee has encouraged proper legislation for improvement of conditions pertaining to school child health, especially along the line of driver training and school bus safety.

The progress of vision and hearing screening is being evaluated and we hope that definite recommendations will soon be forthwith.

It was brought before the committee that chiropractors were trying to serve as doctors at sport activities, especially football. This has become a problem because of the lack of interest by some physicians and possibly because of the lack of understanding between the coaches and physicians in some localities. In order to bring about a better relationship between the Medical profession and those in school athletics, a joint meeting of coaches, trainers, physicians, and athletic directors is planned to be held at the time of the annual coaches meeting in Atlanta in August of this year. Jack Hughes-

ton is serving as Chairman of this Sub-Committee to plan this conference. We hope this conference will be so interesting and beneficial that it may be continued on a yearly basis.

This committee has made an evaluation of immunizations of school age children but no definite action or recommendations are available at this time.

Two members of the state committee, Grady E. Black and Virginia McNamara attended the Seventh National Conference on Physicians and Schools at Highland Park, Illinois on October 13-15, 1959. This conference dealt with school child health problems and was well attended by physicians, health department officials, and leaders in the field of education from all over the United States. The talks and round table discussions gave each participant an opportunity to state the problems of school child health.

The committee feels that a great deal has been accomplished during the past year in school child health but we feel that more progress should be made in the future.

REFERENCE COMMITTEE RECOMMENDATION—The report of the School Child Health Committee was approved and accepted with the recommendation to the House of Delegates that the pre-school physical examination be done by physicians of choice and that polio immunization be required in the pre-school immunization program.

HOUSE OF DELEGATES ACTION—Adopted the report of the School Child Health Committee as amended by the Reference Committee on motion duly made and seconded.

Resolution No. 1

COMMITTEE MEMBERSHIP

SOUTHWEST GEORGIA MEDICAL SOCIETY

WHEREAS, no recognition has been made of the seniority of various delegates to the MAG in the appointments to the various committees, and

WHEREAS, the Association should and could benefit from the experience gained by such seniority,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates suggest to the Council that the appointment of members to committees be made on the basis of seniority in the House of Delegates, that such seniority be based on continuous election to the House and failure to be elected to serve for one term will cancel such seniority accumulated. That such members shall serve on only one committee each year but such appointment may be rotated among the various committees if so desired by Council.

REFERENCE COMMITTEE RECOMMENDATION—The Committee disapproves of this Resolution and feels that the MAG should not be deprived of talented, able, and willing workers because of seniority. We further feel that it is mandatory to have men of knowledge and ability on one or more committees at the same time regardless of tenure.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Reference Committee in disapproving Resolution No. 1: Committee membership on motion duly made and seconded.

Resolution No. 2

STERILIZATION

SOUTHWEST GEORGIA MEDICAL SOCIETY

WHEREAS, there is no specific legislation in this state enabling voluntary sterilization which protects the physician from future liability, and

WHEREAS, as physicians we feel that every individual should have the basic right to obtain such medical services if he or she so desires, and

WHEREAS, we feel that the physician should be fully protected in such cases so as to be able to so serve the Public,

NOW THEREFORE BE IT RESOLVED, that a Committee on Legislation of the Medical Association of Georgia with the aid of the Attorney of the MAG draft such legislation for presentation to the next session of the Georgia Legislature for their consideration.

REFERENCE COMMITTEE RECOMMENDATION—This Committee receives this Resolution as information and wishes to refer this resolution for study and investigation to the Legislation Committee.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Reference Committee in receiving this Resolution as information and referring this Resolution to the Legislation Committee for study and investigation, on motion duly made and seconded.

Supplementary Report of Council No. B

SOCIAL SECURITY

J. G. McDANIEL, M.D., *Chairman*

WHEREAS, the inclusion of physicians within the provisions of Social Security (OASDI-Title II) is under consideration in Congress, and

WHEREAS, this legislation would be unjust and unreasonable as OASDI does not fit the economic pattern of the practicing physician in that self-employed doctors rarely retire at age 65, and

WHEREAS, it is incompatible for physicians to oppose further expansion of OASDI as a method of compulsory health insurance and yet support their inclusion in a system which may abridge their freedom of practice, and

WHEREAS, the 1959 House of Delegates of MAG unanimously opposed inclusion of physicians under OASDI and the AMA House of Delegates unalterably opposes such coverage of the profession,

NOW THEREFORE BE IT RESOLVED, that the MAG Council recommends that the MAG House of Delegates reaffirm its opposition to the inclusion of physicians under OASDI, and

BE IT FURTHER RESOLVED, that the MAG House of Delegates instruct its AMA Delegates to introduce a similar resolution to any AMA House of Delegates meetings until revocation is passed by the MAG House of Delegates.

REFERENCE COMMITTEE RECOMMENDATION—This Committee approves and accepts the Supplementary Report of Council No. B: Social Security.

HOUSE OF DELEGATES ACTION—Adopted the Supplementary Report of Council No. B: Social Security as recommended by the Reference Committee on motion duly made and seconded.

Reference Committee No. 3 Recommendation

COMMITTEE REORGANIZATION

A. J. WATERS, M.D., *Chairman*

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 3 further recommends that because of the number of non-functioning and overlapping committees, a study be made of these committees and that they be merged or discontinued.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee No. 3 recommendation on a study of non-functioning or overlapping MAG Committees to the end that they may be merged or discontinued.

It was moved by Chairman of Reference Committee No. 3, A. J. Waters, Augusta, and duly seconded that the report of Reference Committee No. 3 be accepted as a whole and it was so ordered.

Report of Reference Committee No. 4

Jule C. Neal, M.D., Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendations and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 4 met at 2:30 P. M., May 2, 1960, in Room 710, Ralston Hotel, Columbus. Members of the Committee present were: Jule C. Neal, Macon, Chairman; R. J. Moye, Swainsboro, Secretary; John Tucker, Moultrie; F. O. Garrison, Demorest; L. C. Buchanan, Decatur; John Tate, Rome; J. D. Martin, Atlanta, and A. P. Keller, Athens.

Third District Councilor

W. G. ELLIOTT, M.D., Cuthbert

The Third District held two medical meetings in 1959. The first one was held at Lake Blackshear in the Spring, and the second one was held in Columbus in October. These meetings were fairly well attended and a good program was arranged for each one.

The Fall meeting was held in conjunction with the Fall meeting of the Muscogee County Medical Society.

There are four active societies in the Third District. The largest, Muscogee, is very active and publishes an excellent bulletin each month. The Sumter, Peach Belt, and Flint societies are active, hold regular meetings, and have good programs.

The other four Societies are rather inactive and are rather small. The Vice Councilor, Willis Jordan, has been very active and has attended all Councilor meetings that I have not been able to attend.

Counties and Secretaries	Members December 31, 1959		Members December 31, 1958	
	MAG	AMA	MAG	AMA
Ben Hill-Irvin				
J. E. Smith, Fitzgerald	8	7	9	8
Flint				
J. W. Reynolds,				
Ashburn	16	15	17	16
Peach Belt				
V. W. McEver, Jr.,				
Warner Robins . .	21	19	17	17
Muscogee				
Bruce Newsome,				
Columbus	104	100	104	98
Ocmulgee				
Reid Gullatt,				
Cochran	13	10	14	10
Randolph-Terrell				
R. B. Martin,				
Cuthbert	10	8	13	9

Sumter				
Frank Wilson,				
Leslie	18	17	18	17
Taylor				
E. C. Whatley,				
Reynolds	5	2	5	3
	195	178	199	177

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Third District Councilor and commends him on his activities during the year.

HOUSE OF DELEGATES ACTION—Adopted the report of the Third District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fourth District Councilor

VIRGIL WILLIAMS, M.D., Griffin

The Councilor of the Fourth District has attended all regular and called meetings of the Council during the past year.

During the year, the Councilor has remained in contact with activities of all societies in his district. Numerous informal consultations have been held with members of the Association residing in the Fourth District. Matters concerning policy organizations and ethics have been observed closely by the Councilor. The Fourth District was encouraged to change their program of meeting from twice a year to a quarterly basis. At the present time the Fourth District is meeting on a quarterly basis.

The Councilor feels that the Coweta County Medical Society is deserving of commendation by the Medical Association of Georgia for its splendid work in collecting a vast amount of drugs for use in a Korean Hospital. Their action was in the best tradition of the humanitarian concepts of organized medicine.

The Councilor has been ready at all times to advise on problems pertaining to the office.

Counties and Secretaries	Members December 31, 1959		Members December 31, 1958	
	MAG	AMA	MAG	AMA
Clayton-Fayette				
Wells Riley,				
Jonesboro	5	5	4	4
Coweta				
Ben Jenkins, Newnan	17	6	19	7
Lamar				
S. B. Traylor,				
Barnesville	4	4	4	4
Meriwether-Harris				
J. W. Smith,				
Manchester	14	7	15	8
Newton				
J. W. Purcell,				
Covington	11	10	11	10
Spalding				
H. A. Foster, Griffin	37	34	38	32
Troup				
J. T. Mitchell,				
LaGrange	42	35	39	33
Upson				
N. P. Gardner,				
Thomaston	16	12	17	12
	146	113	147	110

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Fourth District Councilor and commends him on his activities during the year.

HOUSE OF DELEGATES ACTION—Adopted the report of the Fourth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fifth District Councilor

J. G. McDANIEL, M.D., Atlanta

Your Councilor has attended all Council and Executive Committee meetings during the year. It has been my privilege to have been elected Chairman of Council. In this capacity, it has been gratifying to receive the full cooperation of the officers, councilors, and vice councilors and MAG has had a full and active year. We were extremely fortunate to have Dr. Louis Orr, President of AMA address the Fifth District in November, 1959.

Your Vice Councilor, Chas. S. Jones, continues to perform yeoman service in his position as Chairman of the MAG Medical Defense Committee and Co-Chairman of the Insurance & Economics Committee.

Counties and Secretaries	Members December 31, 1959		Members December 31, 1958	
	MAG	AMA	MAG	AMA
DeKalb				
R. I. Gibbs, Decatur	88	78	82	73
Fulton				
Thos. J. Anderson,				
Atlanta	910	731	875	702
	998	809	957	775

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Fifth District Councilor and commends him on his activities during the year.

HOUSE OF DELEGATES ACTION—Adopted the report of the Fifth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Sixth District Councilor

GEORGE H. ALEXANDER, M.D., Forsyth

The Sixth District Councilor has attended all of the regular meetings of Council which have been held during the past year and at the present time is serving on three committees of Council.

The Laurens County Medical Society was visited on February 26, at which time they held a delightful social meeting which was followed by an excellent scientific program given by Harrison Reeves of Atlanta. Except for the Bibb County Society, none of the other societies in the district have been visited, but letters have been written to each of these societies, offering to come to a meeting during the year and to assist them with any problem which might arise within their societies. It is hoped that visits can be made to the remaining societies within the coming months.

The Sixth District Medical Society met at the Macon Hospital in Macon, Georgia on December 2, 1959 at which time an excellent program was presented and the following officers were elected for the coming year: Wm. P. Roche, Dublin, President; E. W. Allen, Jr., Milledgeville, Vice President, and J. T. Hogan, Macon,

Secretary-Treasurer. The spring meeting will be held in Milledgeville during April.

Counties and Secretaries	Members December 31, 1959		Members December 31, 1958	
	MAG	AMA	MAG	AMA
Baldwin				
Fred Crowe,				
Milledgeville . . .	35	17	32	15
Bibb				
John DuPree,				
Macon	154	136	152	137
Jasper				
E. M. Lancaster,				
Shady Dale . . .	4	3	4	3
Jefferson				
J. J. Pilcher, Wrens	8	2	7	3
Laurens				
C. G. Campbell,				
Dublin	35	12	24	10
Washington				
Wm. Rawlings,				
Sandersville . . .	11		12	
	247	170	231	168

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Sixth District Councilor and commends him on his activities during the year.

HOUSE OF DELEGATES ACTION—Adopted the report of the Sixth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Cancer

HOKE WAMMOCK, M.D., Chairman

In preparing this report, the Chairman wishes to commend the excellent report presented by Dr. Everett L. Bishop, the previous Chairman, in the *Journal of the Medical Association of Georgia*, proceedings issue, July, 1959. This report gave a very excellent description of the functions of the Committee on Cancer and the Cancer Control Program in Georgia. My report will in some ways be repetitive, as there have been no significant changes.

The Standing Committee on Cancer is authorized by the Constitution and Bylaws of the Medical Association of Georgia and functions chiefly through its Executive Committee, which is appointed by the President upon recommendation of the Chairman. The Cancer Committee is charged with representing the members of the Medical Association in matters pertaining to cancer, and particularly to advise with the Division of Cancer Control, Department of Public Health, with Dr. W. J. Murphy, Director, Cancer Control Service.

The Committee serves only in an advisory capacity and does not have the authority to enforce its recommendations. It has functioned in a very satisfactory manner in this particular fashion in the past number of years, and without any conflicts.

The budget for the State Aid Cancer Program is \$400,000. It has remained the same for the past five or six years. This, of course, means the budget is getting tighter. Therefore, we must seek ways and means to reduce the cost of the care of the indigent patient, for which this money has been appropriated. The cost of hospitalization has steadily increased at a figure of

about five per cent plus each year. It should be pointed out that the hospital rates (the per diem costs) have not been increased since January, 1958.

The case of load of cancer patients certified for cancer state aid has remained about the same for the past three or four years. This, in part, may be attributable to the referral of some cancer state aid patients for teaching to the Eugene Talmadge Memorial Hospital. This, apparently, has balanced out the anticipated increase in the incidence of cancer. This is perhaps a factor which has permitted the State Aid Cancer Control Program to operate within its budget.

However, the Cancer Control Program is still confronted with the problem of the screening of cancer patients for more efficient care and utilization of the malignant and non-neoplastic cases are still receiving clinical surveys on cancer state aid funds. There is a responsibility that must be borne by the welfare agencies, the local physicians, and the clinics in reducing this cost and by not certifying or accepting patients for cancer state aid funds unless there is a clear indication of malignancy. This cost could be reduced if every patient who is to be certified by a welfare agency were examined by a physician to determine if there were reasonable evidence of malignancy.

During the past year, the Executive Committee has met with Dr. Murphy and many informal discussions with members of the committee by telephone and correspondence have been held. We have met with the Clinic Directors and explored the various possibilities of reducing the cost and yet maintaining efficient care of the cancer patient. With the limited funds provided by this program, many lives are being saved and more could be saved if their disease were recognized earlier and with the administration of prompt and adequate therapy. Fifty per cent of those afflicted with cancer could be cured if their disease were detected in time and adequately treated. This can only be accomplished by a continuation of a program of lay and professional education.

The Cancer Committee and the Georgia Division of the American Cancer Society maintains a very close liaison in the program of service to cancer patients and education to lay and professional groups. The American Cancer Society absorbs a limited amount of the cost of the care of cancer state aid patients by providing transportation, and in a great many incidences this is in voluntary lay groups, and by providing certain pain-relieving drugs and items for the welfare and the care of the patients.

There is a very strong need for a more extensive lay educational program in the rural areas. Unfortunately, there are far too many patients who have advanced disease before seeking medical care.

The professional education is continued by the State Cancer Control Program by providing physicians with the Cancer Bulletin and the distribution of "CA" by the Georgia Division of the American Cancer Society.

In addition to the distribution of printed material, the committee has encouraged the Professional Education Committee of the Georgia Division, American Cancer Society, to intensify its program of providing exhibits and movies at the state Medical Association meetings and to have movies and speakers available for various lay and professional groups throughout the state.

There are now 20 state aid cancer clinics approved by the American College of Surgeons, serving indigent cancer patients. Nineteen of these clinics have tumor registries. There are four other non-state aid cancer clinics that have tumor registries. Each tumor registry collects its own material and copies of this are transmitted to the State Cancer Control Service. This will provide material for evaluation for the care of the cancer patients, and for study.

The Cancer Committee wishes to encourage the interest of all members of the activities of the American Cancer Society. By continued, cooperative effort they will be able to continue an effective Cancer Control Program.

The Chairman wishes to take this opportunity to express his appreciation to all the members of the committee and to Dr. Murphy and to others concerned with the Cancer Control Program, for their helpful ideas and cooperation in maintaining an effective Cancer Control Program. I am certain that we can take pride in the medical service that is being rendered to the indigent cancer patient in the State of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves with commendation the report of Hoke Wam-mock and his Committee on Cancer and particularly wants to restate that the patients have more careful screening before being referred to the various cancer clinics throughout the state.

HOUSE OF DELEGATES ACTION—Adopted the report of the Cancer Committee as recommended by the Reference Committee on motion duly made and seconded.

Maternal and Infant Welfare Committee

EUGENE GRIFFIN, M.D., *Chairman*

As of the date of the Annual Meeting of the Medical Association of Georgia, this Committee will have met at least four times with most members present. A simple statistical analysis is included in this report at the request of the Committee.

There has been a special committee meeting on perinatal mortality studies.

Matters which have been of concern to the Committee are:

1. The continued high maternal death rate. In 1958, a total of 83 maternal deaths were reported, a rate of 8.3 per 10,000 live births.
2. The alarming death rate in the more than 11,000 home deliveries without medical attendants, as compared to the rate in hospital deliveries by physicians. In 1958, 26 of the 83 maternal deaths occurred in relation to home deliveries, with rates of 19.1 for home delivery and 6.6 for hospital delivery.
3. From review of the deaths, there is an apparent lack of appreciation on the part of the public of the value of medical supervision in the prenatal period and of hospitalization for delivery.
4. The apparent lack of willingness on the part of a number of physicians to assume realistic responsibility in doing physical examinations and in signing certificates of safety for home deliveries by lay midwives.
5. The need for up-dating State Health Department

laboratory procedures related to Rh factor determinations.

6. The need for action to implement local blood bank facilities. In 1958 and 1959, eight hospitals had deaths from hemorrhage, apparently due to lack of adequate facilities. In one of these hospitals, there was a second death from hemorrhage.

7. The failure of some physicians and a few local health departments to reply to Committee queries regarding maternal deaths. This blocked review of almost one-third of the cases.

8. The need for more detailed information on replies. Increased number of necropsies to confirm causes of deaths seems indicated.

9. The problem of physician responsibility in repeated preventable maternal deaths.

10. The change in confidential medical information available to the Committee from live birth certificates. No information is now available as to the parity of the mother, which is a significant item.

11. The inability of the State Health Department to implement and enforce the 1955 Lay Midwife Licensure Act, especially as related to problem midwives.

The program of the State Health Department in promoting tetanus immunizations for prenatal patients was approved where tetanus of the newborn is endemic in local midwife patients. Also, approved was the State Health Department program of injectable iron, for prenatal clinic patients with hemoglobin determinations of seven grams or below, who have to be delivered by non-medical attendants in the home, or gratis by medical attendants in the hospital.

The matter of modernization of the Rh procedure was referred to the pathology section by way of Dr. E. J. Sunkes, Director of the Laboratory of the State Health Department.

From review of the maternal deaths, there is still a serious need for public education as to the value of adequate prenatal care, and as to the need for and value of hospital delivery, especially in emergencies. There is still need for easily available hospitalization, at least in times of emergency, for indigent and medically indigent obstetrical patients.

The perinatal mortality studies are to be implemented at last. The pattern to be followed is the one used by the Oklahoma State Medical Association Committee. It has been accepted as the most feasible by a sub-committee and by the State Health Department statistical group, which will be responsible for the compilation of data. Statistical information will be available by hospital and hospital size. Any published information will of necessity be anonymized. However, it will be possible to make pertinent information available to the medical staff of individual hospitals on request.

Almost all cases on which information was available have now been processed by the Committee. The registered letters sent to physicians who had failed to reply to many previous queries were productive.

The Committee offers its sincere thanks to Dr. Luella Klein, Obstetric Consultant Physician of the State Health Department. Through her diligent efforts it has been possible to complete the mass of unfinished business in relation to maternal death studies.

Analysis of Maternal Deaths
Selected Items
Georgia, 1958

	Livebirths	Maternal Deaths	Rate*	
Total	99,870	83	8.3	(U.S. 4.1)
Race				
White	64,097	22	3.4	Delivery status at time of death
Non-white	35,683	61	17.1	Delivered 12
				Died unde-livered 12
Age				Abortions 10
Under 20		8		Ectopic 7
20 through 29		29		Unknown 2
30 through 39		38		
40 or over		8		Some selected cases
				Hemorrhage** 9
				Toxemia*** 20
				Abortion 8
				Ectopic 8
				Infection 5
				**Listed as contributory cause in 29 cases.
				***Listed as cause or contributory cause in 24 cases.
Parity				
Primipara		9		
Grand multipara (7 or more)		18		
Unknown parity		24		
Marital status				Additional significant causes
Married		57	6.3	Ruptured uterus 6
Not now married		26	26.3	Lower Nephron Neph. 5
				Pul embolus 4
Prenatal care (as stated on birth certificate)				Afibrinogenemia 3
None		16		Broncho-pneumonia 2
Inadequate		23		Post partum myocardosis 2
Adequate		15		Tuberculosis 1
Not reported		29		Unrelated trauma 1
Place of delivery				
Home	13,581	26	19.1	
Hospital	86,199	57	6.6	
Attendant				Classification of Deaths
Known midwife cases	11,217	14	12.5	Direct obstetric causes 63
M. D.	88,038	62	7.0	Indirect 16
None		1		Nonrelated 4
D. O. A.		5		
Osteopath		1		

*All maternal death rates are figured per 10,000 live births.

REFERENCE COMMITTEE RECOMMENDATION—This Committee recommends approval and commendation of this report in appreciation of the many problems considered by this committee in their efforts toward solution of these problems.

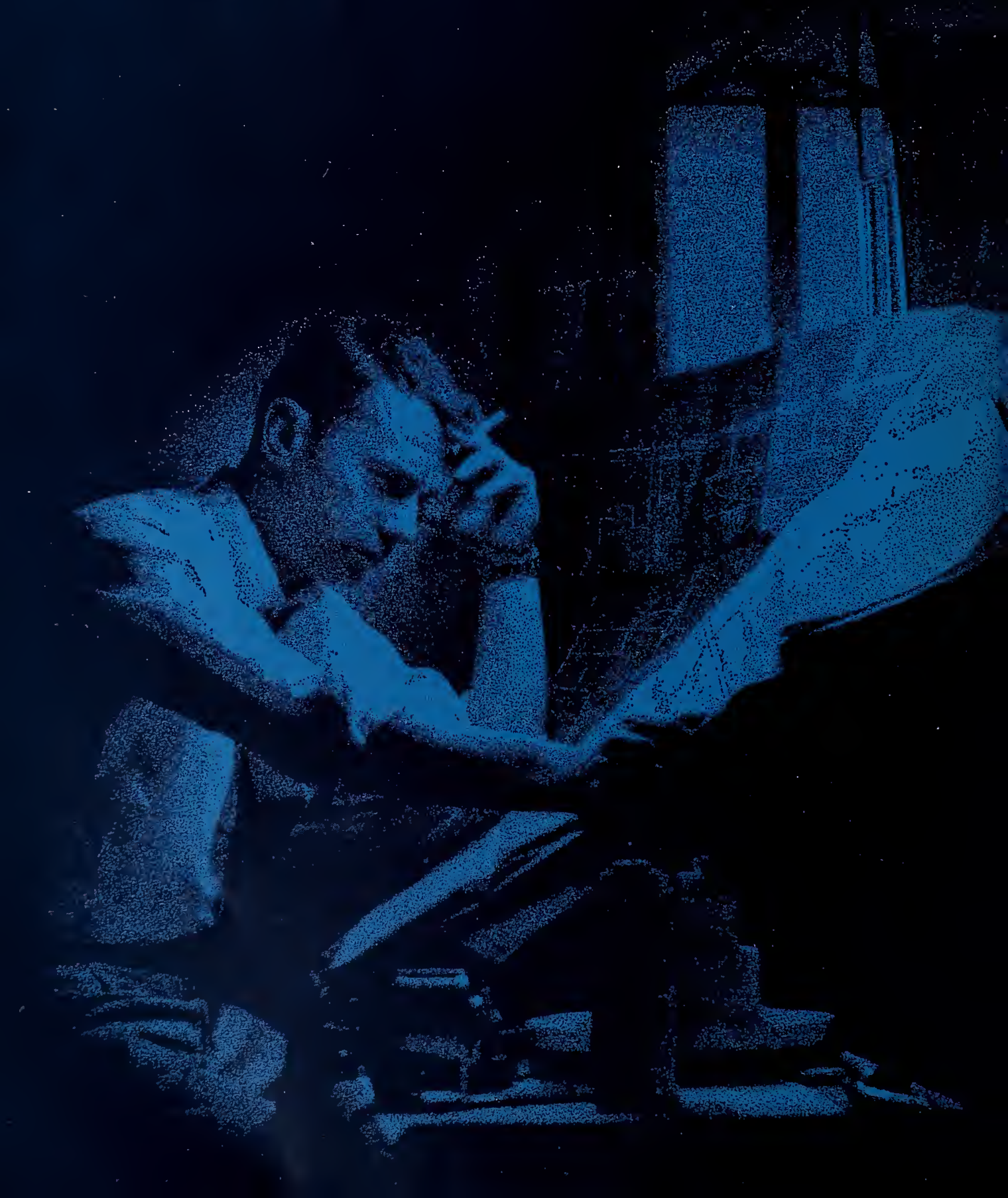
HOUSE OF DELEGATES ACTION—Adopted the report of the Maternal and Infant Welfare Committee as recommended by the Reference Committee on motion duly made and seconded.

Public Health

H. J. BICKERSTAFF, M.D., Chairman

This Committee had no regular or called meetings

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Supplied: **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; **PATHILON** tridihexethyl chloride, 25 mg.


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Administration and Dosage: **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.

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Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

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through the entire year. There were no matters referred to the Committee.

The Chairman will again point out to the House of Delegates that this Committee is a coordinating type of committee being composed of chairmen and members of various other committees whose functions impinge upon matters relative to Public Health. These other numerous committees are all committees of primary function. In the five years or so that I have been chairman, there has been an occasion for the holding of only one meeting. This related to the Asian Flu epidemic of 1957, and the action of this committee might well have been carried out by any of several other committees of the Association had the matter been referred to one of them. In addition, there have been about three or four matters of correspondence that were readily taken care of without the necessity of calling a meeting of the Committee.

The Chairman would like to again direct the attention of the House of Delegates to his repeated recommendation that the Committee on Public Health be abolished as a Standing Committee; also that the function of one of the other committees (for example, the Committee on Rural Health) be expanded to include such matters as occasionally might otherwise be referred to the Committee on Public Health; also that with the expansion of function of such other committee, that it be entitled the Committee on Public Health.

REFERENCE COMMITTEE RECOMMENDATION—This Committee commends the Committee on Public Health for the forthrightness of their report but disagrees with the report. Reference Committee No. 4 believes that there are many needs for this Committee and recommends that the Public Health Committee be continued and that they continue to function as a standing committee of MAG.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of Reference Committee No. 4 recommending that the Public Health Committee be continued and that they continue to function as a standing Committee of MAG.

Woman's Auxiliary Liaison

VIRGIL B. WILLIAMS, M.D., *Chairman*

The committee met with the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia at the Riviera Motel, Atlanta, Georgia, July, 1959. The Advisory Committee reviewed the proposed activities of the auxiliary for the coming year.

Since that meeting, members of the Advisory Committee have been consulted informally on several occasions and have given advice as indicated. The Advisory Committee has been available for advice at all times.

This committee wishes to express its appreciation for the numerous worth-while projects the auxiliary has carried out in the interest of the Medical Association of Georgia during the year. We applaud the officers and the entire membership of the auxiliary for their spirit of cooperation, unselfishness, and valuable aid rendered the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—This Committee approves and accepts the report of the Woman's Auxiliary Advisory Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman's Auxiliary Advisory Committee as recommended by the Reference Committee on motion duly made and seconded.

Medical Civil Preparedness

EDGAR M. DUNSTAN, M.D., *Chairman*

The activities of this Committee for the year 1959-60 may be summarized as follows:

1. Lester M. Petrie, Deputy Director of Georgia Civil Defense Health Services, was asked to prepare a summary report on "progress in Georgia Civil Defense Health Services," and this was distributed to all members of the Committee.

2. Continued in an advisory capacity to the State Civil Defense Health Services Division on medical civil defense matters. In this connection, it was recommended that the pamphlet "Rescue Breathing" be distributed by the Georgia Civil Defense Health Services Division to all State civil defense health service directors throughout Georgia for teaching purposes.

3. Participated in the coordination of activities of the Implementation Committee for Region III (South-eastern states) of the O.C.D.M.

4. Participated in the fourth year of instruction in the course on catastrophic injuries and diseases instituted by the Emory University School of Dentistry as a regular course for senior dental students.

Recommendations:

The Committee recommends that:

1. The composition of the Medical Civil Preparedness Committee continue as at present, namely, one member from each of the key civil defense areas of the State together with any other members at large that the President may wish to appoint.

2. The advisory and coordinating functions of the Committee continue as in the past.

3. Intensified efforts be made to stage practice runs for simulated major disasters in the main cities of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Committee on Medical Civil Preparedness and commends them for their activities during the year.

HOUSE OF DELEGATES ACTION—Adopted the report of the Medical Civil Preparedness Committee as recommended by the Reference Committee on motion duly made and seconded.

VFW Liaison Committee

CHARLES R. ANDREWS, M.D. *Chairman*

This Committee is set up largely as a discussion group of corresponding men, Department of Georgia VFW, to attempt to approach a reconciliation of differences of opinion between MAG and Georgia VFW. It is beyond the hope of this committee to assume that veterans and doctors will ever see eye to eye on all phases; however, it is felt that continued discussions will bring out some statement of agreement between the two groups which may lead to a better understanding and amicable approach with regard to the manner in which veteran cases are handled. It is recommended that this committee be continued.

The Committee also strongly recommends that physicians take more active interest in their local veterans' organizations by virtue of membership and attendance.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Committee on VFW Liaison.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on VFW Liaison as recommended by the Reference Committee on motion duly made and seconded.

Woman's Auxiliary to the Medical Association of Georgia

MRS. REMER Y. CLARK, *President*

As we are about to close the books on our accomplishments and shortcomings for the year 1959-60 we must remember that history, by and large, is told in terms of people and events. The only way the Auxiliary can actually profit by its history is to record and file it as a reference for future guidance.

NATIONAL: On the National level, Georgia is well represented. We have one member on the National Board of Directors, one member is National Legislation Chairman, and another is Southern Regional Chairman, Paramedical Careers Recruitment. At the fall conference in Chicago this year, your president wrote and participated in a membership skit and your Legislation Chairman took part in a legislation skit, copies of both being distributed and used over the entire United States.

STATE: Post-convention Executive Board meeting was held in Augusta, following our convention. The Executive Board meeting was held in Atlanta in June. The Conference and Board meeting was well attended by all State Officers, all State Chairmen, except two, District Councilors and County Presidents. All Auxiliary plans for the year were approved by the Advisory Committee. Winter Executive Board Meeting was held in Macon in January. Our State organization continues to function smoothly and well. During this past year three new auxiliaries have been organized.

COMMUNITY SERVICE: "Yes sir, I know we is all born equal—but some seem to be more equal than others," certainly applies to Doctors' wives when it comes to community service. It is in this realm of service that the Auxiliary can and does make its greatest contribution. Keeping Auxiliary members informed so that they may serve as "Medical Truth Missionaries" has taken top priority this year—particularly in the area of problems of the aged. Emphasis here has been placed on dispensing information through community groups so that the lay public becomes aware of these problems. Project efforts by the Auxiliaries have taken the form of clubs for the senior citizens—"Golden Age," "Silver Hair," etc. Also the furnishing of hospital prayer rooms, patient rooms, and nursing quarters has been the outgrowth of our community service program. Contributions by individual members in positions of health leadership, presentation of health programs, maintenance of speakers' bureaus, work on innumerable committees and drives are hard to calculate (over 100 by actual count on statistical reports).

LEGISLATION: This has been a very active year in the field of Legislation for the Auxiliary. An effort to flood the House Ways and Means Committee of Congress with grass-roots opposition to the Forand Bill was vigorously pursued. Civic organizations have been contacted and urged to pass Resolutions and make their feelings known to Congress. Legislators' wives have been invited as special guests to Auxiliary meetings. The Governor's wife has attended at least two county auxiliary meetings.

AMERICAN MEDICAL EDUCATION FOUNDATION: Importance of this committee has been emphasized. As a result, our contribution will be over \$3,000.00 this year. In comparison to the amounts re-

ceived by our two medical schools, our donations continue to seem pitifully small.

PARAMEDICAL CAREERS RECRUITMENT: There has been sturdy progress in paramedical recruitment demonstrated throughout our county auxiliaries during the past year. This was evidenced in convention of the Allied Medical Careers, Inc. held in Athens, March 26-27. The Auxiliary is one of the four sponsoring groups of this state-wide organization, the stated purpose of which is to promote, stimulate, and support the education and training of young people interested in paramedical careers.

Another significant step forward in our work in Recruitment has been our membership in the "Joint Council on Paramedical Education," a group composed of all the agencies and organizations concerned with paramedical education and recruitment, functioning under the guidance of the State Department of Public Health. Other organizations represented are The Medical Association of Georgia, The University System, Georgia Society of Medical Technologists, Georgia Society of X-Ray Technicians, Georgia Society of Medical Record Librarians, Georgia Dietetic Association, and many other paramedical groups including all the nursing organizations. The "Joint Council" will attempt to coordinate existing facilities for recruitment and training of paramedical personnel. At the present moment the Council is seeking financial aid in the form of research grants in order to do a study of the actual needs and resources in the state of Georgia. Our membership in the "Joint Council" will help us to better utilize our recruitment program to meet the needs of our state.

MENTAL HEALTH: This has been a red letter year for mental health in Georgia. A program has been initiated in which Governor Vandiver says Georgia will rank second to none in the nation. As the result of the Mental Health Committee work in the county auxiliaries: A child Guidance Clinic has been set up in one county; in another county scholarships for training teachers for retardates has been offered; Auxiliary members have led volunteer groups from other organizations in recreational work in schools for mentally retarded; have loaned services in testing programs; assisted in Mental Health programs through PTA groups and co-operated almost 100 per cent with Mrs. Vandiver's Christmas project at Milledgeville; and several auxiliaries have given financial aid to the Chapel of All Faiths.

The Association of our state chairman with the MAG Committee is appreciated by the Auxiliary and has undoubtedly made our contribution to the Mental Health Program more meaningful.

With "*Safety is no Accident*" as our theme for the year many successful safety programs and projects have been sponsored by our Auxiliaries this year, emphasizing child safety, home safety, bicycle safety, and traffic safety, water safety, safety for the aging and fire prevention. One auxiliary sponsored "Courteous Driver Week."

CIVIL DEFENSE has stressed our State Survival plan and Home Preparedness. Members have trained instructors for Red Cross in Home Nursing, attended Leadership Training Courses, conducted Civil Defense Workshops, and put C.D. literature in offices and schools.

THE WILLIAM R. DANCY STUDENT LOAN FUND has been increased this year. We have made

three loans, have three pending, bringing our total to 39 completed. Total worth of this fund is now \$16,480.37.

DOCTOR'S DAY is probably our most enthusiastically endorsed undertaking. All counties continue to honor our physicians on this day in some special way and biographical papers depicting some phase of our medical history are being written each year for our RESEARCH AND ROMANCE OF MEDICINE files.

Our *Auxiliary News*, published quarterly, is an efficient means of disseminating pertinent state and national information to our complete membership. Our STATE DIRECTORY, published annually, is a valued tool of our organization. Our AUXILIARY REPORT, published and distributed at convention, gives complete history of the year's work and serves as a guide for the new year. Your financial support of these publications is very much appreciated.

HEADQUARTERS OFFICE: Please accept our sincere "Thank You" for providing us with office space in the new MAG Headquarters. Along with giving us a meeting place in Atlanta, this office will provide storage space for our Archives and a central location for much of our material which is now scattered around the state.

It is not possible to mention all of the committees and individuals who have contributed so much to the success of this year's program. I have tried to point out how programs inaugurated in previous years have been carried out with increased vigor and new programs interwoven. The wise counsel of my able predecessors has enabled me to follow through the auxiliary program with continuity, in an effort to increase the achievements of previous years.

Since the accomplishments reported here reflect credit upon the officers, chairmen, and doing members of the Auxiliary, and not upon the President, I take pride in making this report, expressing in it sincere appreciation for the loyal cooperation of our Advisory Board from MAG, the entire personnel of the Executive Office, and the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—This Committee recommends approval of this report. We fully realize that as individual doctors and as an Association we could not function effectively without the love, support, and encouragement of our wives and that we welcome this opportunity to say "thank you" one more time.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman's Auxiliary to the MAG as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 5

FLUORIDATION OF WATER SUPPLY MUSCOGEE COUNTY DELEGATION

WHEREAS, the Fluoridation of Public Water Supplies has been shown beyond a question of doubt to have reduced substantially the incidence of dental caries in children and young people, and

WHEREAS, there has been no article in recognized ethical medical literature nor other reputable evidence advanced that indicates that fluoride in water at the recommended concentration has any deleterious effect upon either those individuals in good health or on those individuals suffering from various diseases, and

WHEREAS, members of the dental profession have unanimously endorsed the use of fluorides in the public

water supplies as an effective preventive measure in dental caries, and

WHEREAS, it is the obligation and duty of the medical profession to give advice and recommendations regarding the health of the citizens of our country,

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia and its members go on record as advocating and endorsing the fluoridation of public water supplies in communities where the natural content of fluorides in water is below the optimal level.

REFERENCE COMMITTEE RECOMMENDATION—This Committee recommends approval of this Resolution as written.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 5: Fluoridation of Water Supply as recommended by the Reference Committee on motion duly made and seconded.

Reference Committee No. 4 Recommendation

MEDICAL EDUCATION PROGRAM

JULE C. NEAL, M.D., *Chairman*

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 4 recommends to the House of Delegates that the Medical Association of Georgia adopt as its policy the following principles:

(1) The encouragement of member physicians to participate in medical education programs, presented to the public, such as, radio and TV appearances and public forums, speeches, and newspapers.

(2) That such participation of a member be cleared with his local society beforehand.

(3) That a copy of these principles be sent to all county societies for reading before the society, if approved by the House of Delegates.

HOUSE OF DELEGATES ACTION—Discussion of Reference Committee No. 4 recommendation concerning medical education program participation by physicians ensued. Clarification of Item 2 "That such participation of a member be cleared with his local society beforehand" was also discussed. On motion (Wolff-Waters) it was recommended that the word "scientific" be inserted in Item (1) before the phrase beginning "Medical education programs presented by . . ." thus making Item (1) read as follows: "The encouragement of member physicians to participate in scientific medical education programs presented to the public, such as, radio and TV appearances and public forums, speeches, and newspapers." It was then voted to approve Reference Committee No. 4 recommendation on physician participation in medical education programs as amended by the previous motion by Drs. Wolff and Waters.

It was moved by the Chairman of Reference Committee No. 4, Jule C. Neal, Macon, and duly seconded that the report of Reference Committee No. 4 be accepted as a whole and it was so ordered.

Report of Reference Committee No. 5

Rafe Banks, M.D., *Chairman*

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 5 met at 2:30 P. M., May 2, 1960, in Room 217, Ralston Hotel, Columbus. Members of the Committee present were: Rafe Banks, Gainesville, Chairman; Harry Brill, Columbus, Secretary; Van Bennett, Valdosta; Charles T. Cowart, LaGrange; Wm. Fuller, Augusta; Oscar Lott, Savannah; W. E. Coleman, Hawkinsville, and Phil Astin, Carrollton.

Seventh District Councilor

RALPH W. FOWLER, M.D., Marietta

Counties and Secretaries	Members December 31, 1959		Members December 31, 1958	
	MAG	AMA	MAG	AMA
Bartow				
W. B. Dillard, Cartersville	9	6	9	8
Carroll-Douglas-Haralson				
M. L. Johnson, Bowdon	35	28	31	23
Chattooga				
Hugh Goodwin, Summerville	6	5	6	6
Cobb				
T. J. Vansant, Marietta	72	68	71	66
Floyd				
C. J. Sapp, Rome	57	50	56	46
Gordon				
C. K. Richards, Calhoun	10	7	10	8
Polk				
Charles Smith, Rockmart	13	10	12	9
Walker-Catoosa-Dade				
LeRoy Sherrill Rossville	30	24	31	21
Whitfield				
Herschel Martin, Dalton	29	18	28	21
	261	216	254	208

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 5 unanimously approved the report of the Seventh District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Seventh District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Eighth District Councilor

F. G. ELDRIDGE, M.D., Valdosta

All meetings of Council were attended by the undersigned during the year by Councilor and the Council was entertained and held the December 12-13, 1959 meeting in Valdosta.

Counties and Secretaries	Members December 31, 1959		Members December 31, 1958	
	MAG	AMA	MAG	AMA
Altamaha				
H. L. Morgan, Baxley	7	7	8	8
Coffee				
C. S. Meeks, Douglas	13	6	13	8
Glynn				
Robert Perry, Brunswick	45	42	38	36
South Georgia				
David Branch, Valdosta	50	43	51	43

Telfair

D. B. McRae,
McRae 8 6 8 6

Ware

Henry Adkins,
Waycross 50 40 50 40

Wayne

J. W. Yeomans,
Jesup 8 8 9 9

181 152 177 150

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 5 unanimously approved the report of the Eighth District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Eighth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Ninth District Councilor

CHARLES R. ANDREWS, M.D., Canton

It is a pleasure to continue to serve as Councilor for the Ninth District during the current year. All meetings of Council have been attended by the Ninth District representative and we are proud of the interest and the record of attendance of the Ninth District Vice Councilor, Dr. Scoggins.

Ninth District holds two meetings each year, September and April. These district meetings are well attended and much interest is always shown. Excellent scientific programs are always presented.

Membership remains essentially the same as in the past with slight increase in AMA members as of December 31, 1959 and the slight decrease in total membership has been due to doctors moving away. Below is a breakdown of the eight county societies and their membership:

Counties and Secretaries	Members December 31, 1959		Members December 31, 1958	
	MAG	AMA	MAG	AMA
Blue Ridge				
T. J. Hicks, McCaysville	12	10	11	9
Chattahoochee				
G. S. Tootle, Duluth	19	17	21	16
Cherokee-Pickens				
Ben Looper, Canton	15	11	13	9
Habersham				
Wm. Ariail, Cornelia	16	14	16	15
Hall				
Hamil Murray, Gainesville	46	38	44	39
Jackson-Barrow				
A. A. Rogers, Jr., Commerce	17	12	19	11
Rabun				
J. C. Dover, Clayton	5	4	4	3
Stephens				
R. E. Thompson, Toccoa	16	13	15	12
	146	119	148	114

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 5 unanimously approved the report of the Ninth District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Ninth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Ninth District Vice Councilor

PAUL T. SCOGGINS, M.D., Commrece

Ninth District has been represented by either Councilor, Vice Councilor, or both at all meetings of Council.

Problems of individual county societies have been handled and, when necessary, brought before Council.

The Crawford Long memorial problem has been noted and Vice Councilor will try to get more local help on same.

We hope to attend all meetings the coming year and aid in any manner we can for MAG in this District. Improving in our work and membership will be our goal.

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 5 unanimously approved the report of the Ninth District Vice Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Ninth District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Tenth District Councilor

A. W. SIMPSON, JR., M.D., Washington

As Councilor for Tenth District of the Medical Association of Georgia, I wish to report the past year has been a very good one for our District. All component societies have been active, holding regular scientific meetings.

The Tenth District Society has had one of its best years. A summer meeting was held in Union Point, Georgia, on August 20, 1959. An excellent scientific program was presented and attendance was good.

The winter meeting was held in Athens, Georgia, March 17, 1960, when a symposium on Cardio-Vascular Disease was held.

I attended all but two meetings of Council, being ably represented at those two by David R. Thomas, Vice Councilor, whose presence we will miss over the next three years, due to the fact that the Tenth District Council no longer includes Augusta.

All societies in this district were active in the distribution of information on the Forand bill.

Counties and Secretaries	Members December 31, 1959		Members December 31, 1958	
	MAG	AMA	MAG	AMA
Crawford W. Long				
A. B. Boyd,				
Athens	43	37	45	40
Franklin-Hart-Elbert				
Louis Caccholi,				
Hartwell	24	15	24	15
McDuffie				
Lawrence Cook,				
Thomson	8	8	6	6
Oconee Valley				
George Green,				
Sparta	12	9	13	9

Richmond				
F. N. Harrison,				
Augusta	220	186	222	179
Walton				
Harry B. Nunnally,				
Monroe	10	9	9	9
Warren				
A. W. Davis,				
Warrenton	2	1	2	2
Wilkes				
H. W. Harper,				
Washington	11	8	12	8
	330	273	332	266

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 5 unanimously approved the report of the Tenth District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Tenth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Constitution and Bylaws

THOMAS W. GOODWIN, M.D., *Chairman*

The Constitution and Bylaws Committee recommends the following additions and deletions and changes to the MAG Constitution and Bylaws. These changes were referred to our Committee at the request of the Council, the MAG House of Delegates, etc. Also included for information is the Constitution change on the composition of the Council which was read for the first time at the 1959 session of the House of Delegates and is presented herein for final reading and vote as provided by the present Constitution and Bylaws.

NOW READS:

Section 3(T), COMMITTEE ON GERIATRICS. The Committee on Geriatrics shall concern itself with the medical problems of the aged and chronically ill patient and pursue a continuing study of this problem as it affects the public health.

SHOULD READ:

Section 3(T), COMMITTEE ON AGING. The Committee on Aging shall include as its purposes in reference to "Aging": (1) Study of various aspects of the problem of aging, particularly as they relate to the provisions of medical care; (2) To initiate programs and activities which would provide the medical profession with pertinent information from such studies; and (3) To assume a leadership role in research and in adding to community understanding of the aging process and its implications to the individual. In reference to the "Aged" the purpose of the committee should include: (1) To be informed on problems which exist or may arise in the area; (2) To initiate activities and cooperate with other groups in activities designed to meet these problems; and (3) To inform the profession of public health problems and activities and of their responsibility in this field.

REFERENCE COMMITTEE RECOMMENDATION—Bylaws, Chapter IX, Section 3 (T), Committee on Aging—This change was unanimously approved.

HOUSE OF DELEGATES ACTION—Adopted the amendment to the Bylaws, Chapter IX, Section 3 (T), Committee on Aging as recommended by the Reference Committee on motion duly made and seconded.

SHOULD READ:

Section 4, LECTURESHIPS (A). Lectureships for presentation at general meetings may be established by interested donors honoring distinguished deceased members or former members of the Medical Association of Georgia or honoring someone not a former member or physician who has rendered distinguished service to the Medical Association of Georgia or to Georgia medicine.

Section 4(B). Council of the Medical Association of Georgia must approve all lectureships and they must meet the following provisions: (1) Medical Association of Georgia will control the programming of all approved lectureships; (2) That any lectureship, if approved, must be established by setting up a trust fund which shall be in accordance with the present pattern of the lectureship trust fund; (3) The amount of any new lectureship trust fund must be approved by Council; (4) A representative of the lectureship trust fund shall be invited to submit suggestions concerning the choice of speakers. Such representatives shall be chosen by Council from three nominees, who must be members of MAG, to be submitted by the donor or the trustee of the lectureship fund.

NOW READS:

Section 4. The General meeting shall be opened
.....

SHOULD READ:

Section 5. The general meeting shall be opened
.....

NOW READS:

Section 5. Local arrangements committee. As soon as practicable

SHOULD READ:

Section 6. Local arrangements committee. As soon as practicable

REFERENCE COMMITTEE RECOMMENDATION—Bylaws, Chapter II, General Meetings, Section 4 (A)—The substituted paragraph was approved unanimously. The new Section 4 (B) was also approved unanimously. Also in Chapter II, the renumbering of the present Section 4 to read Section 5 and Section 5 to read Section 6 was approved unanimously.

HOUSE OF DELEGATES ACTION—Adopted the amendment to the Bylaws, Chapter II, General Meetings, Section 4 (A) & (B) and the renumbering of the present Section 4 to read Section 5 and Section 5 to read Section 6 as recommended by the Reference Committee on motion duly made and seconded.

The 1959 House of Delegates approved certain changes recommended by the Constitution and Bylaws Reference Committee for the first reading only. The following Article VI, Council, Section 1, Composition and Article IX, Officers, Section 1, Designation which have been approved for the first reading only are up for a second reading as follows:

NOW READS:

Article VI, COUNCIL. Section 1. COMPOSITION. Council is composed of the President, President-Elect, the Immediate Past President, two Vice Presidents, Secretary, Speaker of the

House of Delegates and ten Councilors as provided for in the Bylaws. The Treasurer, Editor of the Journal, Executive Secretary, and Delegates to the AMA shall be Ex-Officio members of Council without the right to vote. Vice Councilors shall be Ex-Officio members except in the absence of their respective Councilors as provided for in the Bylaws. The Vice Speaker shall be an Ex-Officio member except in the absence of the Speaker as provided for in the Bylaws.

SHOULD READ:

Article VI, COUNCIL. Section 1. COMPOSITION. Council is composed of the President, the President-Elect, the Immediate Past President, two Vice Presidents, Secretary, Speaker of the House of Delegates and Councilors as provided for in the Bylaws. Delegates to the AMA, the Treasurer, Editor of the Journal and the Executive Secretary shall be Ex-Officio members of Council without the right to vote. Vice Councilors shall be Ex-Officio members except in the absence of their respective Councilors as provided for in the Bylaws. The Vice Speaker shall be an Ex-Officio member except in the absence of the Speaker as provided for in the Bylaws.

REFERENCE COMMITTEE RECOMMENDATION—Constitution, Article VI, Council, Section 1, Composition—This Committee voted unanimous approval of the rewording of the amendment as written for second reading.

HOUSE OF DELEGATES ACTION—Adopted the rewording of the amendment to the Constitution, Article VI, Council, Section 1, Composition, as recommended by the Reference Committee on motion duly made and seconded.

NOW READS:

Article IX, OFFICERS. Section 1. DESIGNATION. The officers of the Association shall be a President, President-Elect, two Vice Presidents, the Immediate Past President, the Secretary, Speaker of the House of Delegates, the Vice Speaker of the House of Delegates, ten Councilors and ten Vice Councilors as provided for in the Bylaws.

SHOULD READ:

Article IX, OFFICERS. Section 1. DESIGNATION. The officers of the Association shall be a President, President-Elect, two Vice Presidents, the Immediate Past President, the Secretary, the Speaker of the House of Delegates, the Vice Speaker of the House of Delegates, the Councilors and Vice Councilors as provided for in the Bylaws.

REFERENCE COMMITTEE RECOMMENDATION—Constitution, Article IX, Officers. Section 1, Designation—Reference Committee No. 5 voted unanimous approval of the rewording of the amendment for second reading.

HOUSE OF DELEGATES ACTION—Adopted the amendment of the Constitution, Article IX, Officers. Section 1, Designation as recommended by the Reference Committee on motion duly made and seconded.

The Reference Committee also recommended the following changes in bylaws which were tabled (1959) until the Constitution changes are made as recommended for second reading of the above. These bylaw changes are dependent on the action of the House of Delegates on the Constitution changes cited above as follows:

NOW READS:

Chapter IV. COUNCIL, Section 1, COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past President, two Vice Presidents, Secretary, Speaker of the House of Delegates or the Vice Speaker of the House of Delegates, one Councilor or Vice Councilor from each Councilor District. Vice Councilors shall be Ex-Officio members of Council without the right to vote except in the absence of their respective Councilors when they shall serve as Councilors. The Vice Speaker shall be an Ex-Officio member of the Council without the right to vote except in the absence of the Speaker when he shall serve in the Speaker's stead. Treasurer, Editor of the Journal, Executive Secretary and Delegates to the AMA shall be Ex-Officio members of Council without the right to vote.

SHOULD READ:

Chapter IV. COUNCIL, Section 1, COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past President, two Vice Presidents, Secretary, Speaker of the House of Delegates or Vice Speaker of the House of Delegates and one Councilor or Vice Councilor from each Councilor District. Component County Medical Societies having one hundred or more active members shall be entitled to elect one Councilor and one Vice Councilor directly representing that society. In these elections, only members of the component county medical society involved shall be allowed to vote and in those districts which contain the large county medical societies having one hundred or more active members, only those members residing in the district outside the large county medical society may vote for the Councilor representing that district. Vice Councilors shall be Ex-Officio members of Council without the right to vote except in the absence of their respective Councilors when they shall serve as Councilors. The Vice Speaker shall be an Ex-Officio member of Council without the right to vote except in the absence of the Speaker when he shall serve in the Speaker's stead. Delegates to the AMA, the Treasurer, Editor of the *Journal* and the Executive Secretary shall be Ex-Officio members of Council without the right to vote.

REFERENCE COMMITTEE RECOMMENDATION—Bylaws, Chapter IV. Council, Section 1, Composition—Reference Committee No. 5 voted unanimous approval of this change in the Bylaws.

HOUSE OF DELEGATES ACTION—Adopted the amendment to the Bylaws, Chapter IV. Council, Section 1, Composition, as recommended by the Reference Committee on motion duly made and seconded.

An additional paragraph is herein presented by the Constitution and Bylaws Committee enabling clarification of the above cited pending changes in the Constitution and Bylaws. Such paragraph would be added to Chapter V, Section 2, Nominations, to read as follows:

"Nominations from those county medical societies having 100 or more active members which are entitled to elect one Councilor and one Vice Councilor directly representing that society shall be forwarded in like manner as a district society for election by ballot by the members of the Association during the Annual Session."

REFERENCE COMMITTEE RECOMMENDATION—Bylaws, Chapter V. Council, Section 2, Nominations—Reference Committee No. 5 approved the additional paragraph as recommended by the Constitution and Bylaws Committee.

HOUSE OF DELEGATES ACTION—Adopted the amendment of Bylaws, Chapter V. Council, Section 2, Nominations, in adding an additional paragraph to this Section as recommended by the Reference Committee on motion duly made and seconded.

Supplementary Report of Constitution & Bylaws Committee No. C

ANNUAL SESSION DATE

THOMAS W. GOODWIN, M.D., *Chairman*

The Committee recommends amendment to Article VII as follows:

Now Reads:

Section 1. Annual Session. The Association shall hold an Annual Session at a time and place fixed by Council.

Will Read:

Section 1. Annual Session. The Association shall hold an Annual Session beginning on the first Sunday in May as approved by Council.

REFERENCE COMMITTEE RECOMMENDATION—Constitution, Article VII, Meetings, Section 1, Annual Session—Reference Committee No. 5 unanimously approved this recommendation for first reading.

HOUSE OF DELEGATES ACTION—Adopted the Supplementary Report of the Constitution and Bylaws Committee No. C: Annual Session Date for first reading as recommended by the Reference Committee on motion duly made and seconded.

Hospital Relations

MILFORD B. HATCHER, M.D., *Chairman*

Due to its composition and ramifications within all aspects of medical practice, the Hospital Relations Committee has again this year attempted to correlate and act as liaison between many groups interested in the practice of medicine and their relations to hospitals.

The Georgia Hospital-Medical Council, which has been largely developed through the Hospital Relations Committee, has completed its program of hospital standards with inspection and accreditation of the smaller hospitals throughout the State. The program has been very enthusiastically received by a large number of the smaller hospitals, and it is hoped that in the very near future all of the smaller hospitals can be inspected and accredited if they meet certain standards. The Villa Rica Hospital at Villa Rica, Georgia was first to have been accredited.

The Hospital Relations Committee through its Georgia Hospital-Medical Council, is very happy to report that there has been no problem to arise in which mediation between hospital, physicians, or trustees was necessary during the year. It might be recalled that this was the initial purpose in forming this Council.

The para-medical recruitment program and training program throughout the State continues to be somewhat in chaos. This committee feels that this is a problem which cannot be handled completely through the Medical Association and/or any one of its committees, but it feels that it will have to be done on a State-wide basis with the correlation of various agencies which are now involved in para-medical (Medical careers) recruitment. It is felt that the Governor of the State of Georgia should appoint a study commission in regard to

para-medical (Medical Careers) recruitment and attempt to bring order out of this chaos, and that the Medical Association of Georgia through one of its committees, whether an existing committee or a new committee, take a very active part and the lead in this endeavor. It is felt that it would be better if the Medical Association of Georgia Hospital Relations Committee be broken down into subcommittees, being composed of the members of the Georgia Hospital-Medical Council, a subcommittee for para-medical (Medical Careers) recruitment, and one with relations with the division of hospital services, State Department of Health, or the most feasible working arrangement the committee deems satisfactory. Thus, all of the affairs related to hospital practice continue under this one head.

The Hospital Relations Committee recommends that the Medical Association of Georgia write the Governor of the State of Georgia to gain his support in initiating the Georgia Health Indigent Care Law which was passed in 1958.

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 5 Committee unanimously approved the report of the Hospital Relations Committee and referred the recommendation given in paragraph 4 to Council for appropriate action. Reference Committee No. 5 also voted unanimously to commend the Hospital Relations Committee for its excellent work.

HOUSE OF DELEGATES ACTION—Adopted the report of the Hospital Relations Committee as recommended by the Reference Committee on motion duly made and seconded.

Medical Defense

CHARLES S. JONES, M.D., *Chairman*

The Medical Defense Committee has been both active and successful in its operation this year. Highlighted is the annual negotiation with the St. Paul Mercury Companies at which time rates for most types of coverage were materially reduced. It is by this method of annual conference between representatives of the Medical Association and the insurance carrier that we will be able to stay abreast of the latest developments in this type of insurance coverage and gain the maximum advantage in premium reductions.

Throughout the state, our Medical Defense Committees have cooperated beautifully in investigating potential claims. In this regard a most serious, frequent mistake made by doctors is critical comment concerning the work or results of another doctor. Almost invariably this comment is given without adequate knowledge of the case involved. All doctors should obtain complete information on any case before they offer an opinion.

It is gratifying to report that membership under this program has substantially increased and now includes a majority of the doctors practicing in Georgia.

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 5 unanimously approved the report of this Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Medical Defense Committee as recommended by the Reference Committee on motion duly made and seconded.

Public Service

JOHN P. HEARD, M.D., *Chairman*

The Public Service Committee has met several times during the year. An Officer's Conference, to indoctrinate the new County Society Officers, was held in

Atlanta on February 14, 1960. This was a full day program, which seemed to be appreciated by the new officers.

A supplemental section to the *Columbus Ledger-Enquirer* is to be issued the Sunday that the annual session opens in Columbus. This is a newspaper section devoted entirely to medical and health news for the lay reader.

Work was done on automobile safety during the past year. Several resolutions were passed to this Committee from the House of Delegates at the last annual session. A good bit of "behind-the-scenes" work was done by meeting with the State Safety Director and by working with civic clubs and other organizations to secure their interest. Council cooperated by making available funds for an enlarged program to help the Safety Director pass many of his requested measures in the Legislature, but circumstances indicated that more pressing matters in the Legislature would cause a safety program to bog down, and this proved to be true. Medical Societies and individual physicians were urged to contact their Legislators to support a safety program but it was felt unwise to spend a large sum of money without better assurance of success.

The Public Service Committee has cooperated with the Health Care of the Aging Committee in fighting the Forand bill. This Committee aided in a special state program to indoctrinate County Society Officers and has participated in numerous local programs on the society level.

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 5 unanimously approved the report of this Committee. Reference Committee No. 5 wishes to recommend that the House of Delegates officially commend the Columbus news media for their excellent coverage and cooperative efforts during the Association's *106th Annual Session, May 1-4, 1960. It is especially noted that the personnel representing the newspapers, radio, and television were outstanding in their reporting of the convention activities during this session.

HOUSE OF DELEGATES ACTION—Adopted the report of the Public Service Committee and the additional recommendation of Reference Committee No. 5 concerning the commendation of Columbus news media as recommended by Reference Committee No. 5 on motion duly made and seconded.

Weekly Health Column

AUGUST S. YOCHER, JR., M.D., *Chairman*

The Weekly Health Column Committee met five times during the past year, on May 27, September 20, November 11, March 23, and April 20. During the year, a new article was mailed each Monday from the MAG Headquarters Office to 200 weekly newspapers throughout Georgia, making a total of more than 10,000 pieces of mail.

We feel that the column is serving an excellent public relations purpose by providing the public with interesting reading material on health and medical subjects. We wish to thank our professional writer who assists in editing the columns for a very modest amount of money.

Subjects selected have ranged from traffic safety to cancer and heart disease. Any members who have suggestions for the column are invited to communicate with the Committee. We would appreciate any ideas relating to subject matter or ways in which the column can be improved.

The work of this Committee was launched by How-

ard Derrick of Lafayette who was Chairman during 1958 and 1959. All the members of the Committee feel that his work was instrumental in getting this project started. We wish to officially thank him for his fine work. Due to the press and other business, Dr. Derrick had to resign as a member of this Committee in January.

The members of this Committee who helped prepare numerous articles for publication also deserve a vote of thanks for diligence and interest in the column.

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 5 approved unanimously the report of this Committee and commended Howard Derrick and the individual members of this Committee for their diligent work.

HOUSE OF DELEGATES ACTION—Adopted the report of the Weekly Health Column Committee as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 3

NURSING COMMISSION

FULTON COUNTY MEDICAL SOCIETY

WHEREAS, the report of the Georgia Commission on Nursing supports the fact that a nursing shortage does exist in Georgia, and

WHEREAS, the program of Nursing Education for Georgia, and our supply of nurses is contingent upon the National Nursing Program,

THEREFORE BE IT RESOLVED, that the Medical Association of Georgia approve the report of the Georgia Commission on Nursing, and

BE IT FURTHER RESOLVED, that the Medical Association of Georgia request the American Medical Association to appoint a Commission on Nursing to study the National Nursing Program and give special study to the Accreditation Program of the National League for Nursing and to the method of scoring used by the American Nurses Association Committee on State Boards.

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 5 unanimously approved this resolution presented by the Fulton County Medical Society.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 3: Nursing Commission as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 4

BROADCASTING PRACTICES

FULTON COUNTY MEDICAL SOCIETY

WHEREAS, television programs are frequently ob-

jectionable to the medical profession; and

WHEREAS, the doctor in some instances is erroneously presented as recommending a product; and

WHEREAS, the druggist is frequently shown in the act of prescribing certain products for illness; and

WHEREAS, some reputable pharmaceutical firms sell their products to the accompaniment of the most sadistic and incompatible programs fostering man's inhumanity against man rather than contributing to his well being;

THEREFORE BE IT RESOLVED, that the Medical Association of Georgia go on record as deploring such practices of broadcasting companies and sponsors; and

BE IT FURTHER RESOLVED, that the intent of these resolutions be conveyed to the House of Delegates to the American Medical Association with a plea for action on the National Level.

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 5 approved unanimously this Resolution No. 4 presented by the Fulton County Medical Society.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 4: Broadcasting Practices as recommended by the Reference Committee on motion duly made and seconded.

It was moved by the Chairman of Reference Committee No. 5, Rafe Banks, Gainesville, and duly seconded that the report of Reference Committee No. 5 be accepted as a whole and it was so ordered.

Unfinished Business

Speaker Goodwin called for unfinished business and none was introduced.

New Business

Speaker Goodwin called for new business and recognized President Luther H. Wolff, Columbus. Dr. Wolff expressed his appreciation to the House of Delegates and the membership of the Medical Association of Georgia for their interest and cooperation during his presidential year 1959-60.

There being no further business, speaker Goodwin adjourned the Second Session of the House of Delegates of the Medical Association of Georgia held in conjunction with the *106th Annual Session of the Association at 10:10 A. M.

**The *107th Annual Session of the Medical Association
of Georgia will be held May 7-10, 1961, in
Atlanta, Georgia.**

GENERAL BUSINESS SESSION

***106th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA**

SUNDAY, MAY 1, 1960

THE FIRST GENERAL BUSINESS SESSION of the *106th Annual Session of the Medical Association of Georgia was called to order by President Luther H. Wolff, Columbus, at 2:00 P. M. in the Municipal Auditorium, Columbus, Georgia, on May 1, 1960.

President Wolff stated that the next order of business was nominations of Officers and Councilors and he announced the appointment of a Tellers Committee of Willis P. Jordan, Columbus, Chairman and Charles Richardson, Sr., Macon. Dr. Wolff clarified voting rules and voting hours which were to begin immediately following nominations at this session; to close at 5:00 P. M., then again to open at 9:00 A. M. to 5:00 P. M. Tuesday, May 3, closing the ballot box at that time.

President Wolff then called for nominations from the floor for Association Officers and the nominations were made as follows:

Nominations

President-Elect—Fred Simonton, Chickamauga; nominated by William Harbin, Rome; seconded by Charles Richardson, Sr., Macon; Howard C. Derrick, Lafayette, and Eustace A. Allen, Atlanta.

There being no other nominations for the office of President-Elect, President Wolff instructed the Secretary to cast a unanimous ballot for Fred Simonton as President-Elect for the Medical Association of Georgia.

First Vice President—Simone Brocato, Columbus; nominated by Charles Smith, Columbus; seconded by John Elliott, Savannah and W. G. Elliott, Cuthbert.

There being no further nominations, President Wolff instructed the Secretary to cast a unanimous ballot for Simone Brocato, Columbus, as First Vice President of the Association.

Second Vice President—Braswell E. Collins, Macon; nominated by David R. Thomas, Jr., Augusta; seconded by George Alexander, Forsyth.

There being no other nominations, President Wolff instructed the Secretary to cast a unanimous ballot for Braswell E. Collins, Macon, as Second Vice President of the Association.

Secretary—Chris J. McLoughlin, Atlanta; nominated by Don Cathcart, Atlanta; seconded by Lee Howard, Sr., Savannah; John Davidson, Columbus, and Alton Hallum, Atlanta.

Secretary—John T. Mauldin, Atlanta; nominated by Lamar Peacock, Atlanta; seconded by Howard C. Derrick, LaFayette; William Coles, Atlanta, and George Hutto, Columbus.

AMA Delegate (term beginning January 1, 1961)—Eustace A. Allen, Atlanta; nominated by Sterling Claiborne, Atlanta; seconded by Charles Richardson, Sr., Macon; J. G. McDaniel, Atlanta, and Lee Howard, Savannah.

There being no other nominations, President Wolff instructed the Secretary to cast a unanimous ballot for the election of Eustace A. Allen, Atlanta, as AMA Delegate.

AMA Alternate Delegate (term beginning January 1, 1961)—Thomas McGoldrick, Savannah; nominated by John Elliott, Savannah; seconded by David R. Thomas, Augusta, and Charles Richardson Sr., Macon.

There being no other nominations, President Wolff instructed the Secretary to cast a unanimous ballot to elect Thomas McGoldrick, Savannah, Alternate Delegate to the AMA.

AMA Delegate (term beginning January 1, 1961)—Henry H. Tift, Macon; nominated by Charles Richardson, Sr., Macon; seconded by F. G. Eldridge, Valdosta, and Lee Howard, Savannah.

There being no other nominations, President Wolff instructed the Secretary to cast a unanimous ballot electing Henry H. Tift, Macon, as AMA Delegate.

AMA Alternate Delegate (term beginning January 1, 1961)—W. G. Elliott, Cuthbert; nominated by Henry H. Tift, Macon; seconded by George Hutto, Columbus.

There being no other nominations, President Wolff instructed the Secretary to cast a unanimous ballot electing W. G. Elliott, Cuthbert, as AMA Alternate Delegate.

President Wolff then referred to Chapter IV, Section 2 of the MAG Constitution and Bylaws as follows: "Nominations for Councilors and Vice Councilors shall be made by each District at its annual meeting and forwarded by the Secretary to the Secretary of the Association not less than 15 days before the Annual Session. If no nomination has been presented by a district society in this manner, nominations shall be made from the floor.

President Wolff then read the nominations from the Ninth and Tenth District Medical Societies received according to the Constitution and Bylaws as follows:

Ninth District Councilor—Charles Andrews, Canton.

Ninth District Vice Councilor—Paul Scoggins, Commerce.

Tenth District Councilor—Addison Simpson, Jr., Washington.

Tenth District Vice Councilor—M. A. Hubert, Athens.

President Wolff then stated that the only contested office from the nominations of Officers and Councilors was that of Secretary and so instructed the Tellers Committee.

GP of the Year Award

President Wolff stated that according to the rules

of the presentation of the "General Practitioner of the Year" award, the MAG council had received two nominations for this honor. President Wolff called on Chairman of Council J. G. McDaniel who presented the two following nominations:

Jack Guy Standifer, Blakely, nominated by the Southwest Georgia Medical Society.

J. M. Mixon, Valdosta, nominated by the South Georgia Medical Society.

Dr. Wolff called for nominations from the floor and there being none, he informed the general membership that the House of Delegates would vote on these two candidates for this high honor at the First Session of the House of Delegates.

Hardman Award

President Wolff stated that the Committee of Council received nominations for the Hardman

Award and he presented these nominations as follows:

S. Ernest Vandiver, Governor, State of Georgia, nominated by the Council of the Association.

Robert C. Pendergrass, Americus, nominated by the Southwest Georgia Medical Society.

Dr. Wolff explained that according to the rules for the awarding of this honor, only nominations received by Council would be considered and, further, that the House of Delegates would vote on these nominees at the First Session of the House of Delegates.

There being no further business, the First General Business Session of the *106 Annual Session of the Medical Association of Georgia was recessed at 2:40 P. M.

GENERAL BUSINESS SESSION (Second Session)

***106th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA**

MONDAY, MAY 2, 1960

THE SECOND GENERAL BUSINESS SESSION of the *106th Annual Session of the Medical Association of Georgia was called to order by President Luther H. Wolff, Columbus, at 12:05 P.M. in the Municipal Auditorium, Columbus, Georgia, on May 2, 1960.

The Invocation was given by the Rev. Richard N. Robertson, Chaplin, The Medical Center, Columbus, Georgia.

A word of welcome was delivered by Simone Brocato, Columbus, President of the Muscogee County Medical Society and Chairman of the Annual Session Local Arrangements Committee. He welcomed the members of the Medical Association of Georgia to Columbus for the 1960 Annual Session and extended the best wishes of the Mayor of Columbus, B. (Ed) Johnson.

President Wolff turned over the gavel to First Vice President Corbett Thigpen. Dr. Thigpen then introduced President Luther H. Wolff who addressed the membership on the subject "Report of the Presidential Year 1959-60."

Upon completion of the President's speech, Luther Wolff again assumed the duties of presiding officer.

President Wolff then introduced President-Elect Milford B. Hatcher, Macon, who addressed the membership on the subject "The Association Future 1960-61."

Upon completion of the address by President-Elect Milford Hatcher, Dr. Wolff recessed the Second General Business Session of the *106th Annual Session of the Medical Association of Georgia at 1:00 P.M.

GENERAL BUSINESS SESSION (Third Session)

***106th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA**

WEDNESDAY, MAY 4, 1960

THE THIRD GENERAL BUSINESS SESSION of the *106th Annual Session of the Medical Association of Georgia was called to order by President Luther H. Wolff, Columbus, at 11:00 A.M. in the Municipal Auditorium, Columbus, Georgia, on May 4, 1960.

President Wolff announced that a compilation of the official attendance at the *106th Annual Session of the Medical Association of Georgia was as follows: Physicians Registered—679; Guests Registered—59; Exhibitors Registered—141, making a grand total of 879 registrants.

Fifty Year Certificates

President Wolff called on J. G. McDaniel, Chairman of MAG Council, who presented Fifty Year Certificates and pins to physicians who have practiced medicine for 50 years or more. These presentations were made to the following physicians: Carl C. Aven, Atlanta; Victor H. Bennett, Gay; J. E. Davis, Atlanta; H. L. Earl, Sparta; Clifford C. Elliott, Sargent; Claude W. Harvey, Hoganville; D. C. Kelley, Lawrenceville; W. F. Massey, Chester; Robert L. Rhodes, Augusta; J. R. Robertson, Augusta; Thomas E. Rogers, Macon (Dec.); Dan Y. Sage, Atlanta, and Ralph C. Williams, Atlanta.

Scientific Exhibit Awards

President Wolff called upon Ted F. Leigh, Atlanta, Chairman of the Association Scientific Awards Committee, who made the following presentations:

First Place Award—"Surgery of the Tympanic Membrane and Middle Ear"—

Claude L. Pennington, M.D., Macon.

Second Place Award—"The Suturing of Small Arteries"—

Harold S. Engler, M.D.; William M. Headley, M.D., and William H. Moretz, M.D., Augusta.

Third Place Award—"The Polycystic Ovary Syndrome"—

Robert B. Greenblatt, M.D.; William E. Barfield, M.D.; and Edwin C. Jungck, M.D., Augusta, and Kenneth R. Baldwin, M.D., Richmond, Virginia.

Honorable Mention—"Ankle Sprains and Subluxations"—

George S. Whatley, M.D., Columbus.

Honorable Mention—"Intra-arterial Large Particle Isotopes and Isolation Perfusion with Chemicals for Advanced Cancer"—

Edgar D. Grady, M.D.; Walter Sale, M.D.; William E. Schatten, M.D.; and Luther Rollins, M.D., Atlanta.

Honorable Mention—"Cardiac Resuscitation"—

William A. Hopkins, M.D.; James B. Minor, M.D.; M. Bedford Davis, M.D.; William C. Wansker, M.D.; and Lester Rumble, M.D., Atlanta.

GP of the Year Award

President Wolff called on Fred Simonton to present the GP of the Year Award. Dr. Simonton pre-

sented the 1960 "General Practitioner of the Year" award to John Guy Standifer, Blakely, Georgia.

Certificates of Appreciation

President Wolff called on Chris J. McLoughlin, Association Secretary, to present the MAG Certificates of Appreciation. Dr. McLoughlin presented the following Certificates of Appreciation in behalf of the Association: Howard C. Derrick, Jr., Lafayette, as Chairman of the Weekly Health Column Committee; Lee Howard, Sr., Savannah, as Councilor to MAG; J. T. Holt, Baxley, for Civic Service; Mrs. Remer Y. Clark, Marietta, as President of the Auxiliary to the MAG; Mr. John D. Arndt, Atlanta, as former Medicare Administrator; W. Bruce Schaeffer, Toccoa, as Chairman of the Milledgeville Study Committee and MAG Councilor; Charles Richardson, Sr., Macon, as MAG Delegate to the American Medical Association.

Hardman Cup Award

President Wolff called on Milford B. Hatcher, President-Elect, to present the Hardman Cup Award. Dr. Hatcher presented the Hardman Cup Award and Certificate to Governor S. Ernest Vandiver and this presentation was received by Mr. Henry Neal, Attorney General's staff, for Governor Vandiver. Mr. Neal voiced the Governor's appreciation for this high honor.

Distinguished Service Award

President Luther Wolff announced that a secret committee for the selection of the recipient of the Distinguished Service Award had chosen Enoch Callaway, LaGrange, to receive this high honor. Dr. Wolff then presented the 1960 MAG Distinguished Service Award to Enoch Callaway of LaGrange.

Dr. Wolff also presented the 1958 Distinguished Service Award to Allen Bunce, Atlanta, who received this award some two years earlier, but because of difficulties in the design of the award had not actually received the plaque.

Election Results

President Wolff called on Willis P. Jordan, Chairman of the Tellers Committee, who reported that a majority of votes had been cast for John T. Mauldin as Secretary of the Medical Association of Georgia.

President Wolff recognized Chris J. McLoughlin who requested that his name be withdrawn and that the membership cast a unanimous vote for John T. Mauldin. President Wolff then expressed the Association praise and appreciation for the services rendered to MAG by Dr. McLoughlin during his term as Association Secretary.

Installation of Officers

The next order of business was the installation of the 1960 officers which are as follows:

President—Milford B. Hatcher, Macon (1961)
President-Elect—Fred Simonton, Chickamauga (1961)
Immediate Past President—Luther H. Wolff, Columbus (1961)
First Vice President—Simone Brocato, Columbus (1961)
Second Vice President—Braswell E. Collins, Macon (1961)
Secretary—John T. Mauldin, Atlanta (1963)
Speaker of the House—Thos. W. Goodwin, Augusta (1962)
Vice Speaker of the House—J. Frank Walker, Atlanta (1962)
AMA Delegate (term beginning January 1, 1961)—Eustace A. Allen, Atlanta (December 30, 1962)
AMA Alternate Delegate (term beginning January 1, 1961)—Thomas McGoldrick, Savannah (December 30, 1962)
AMA Delegate (term beginning January 1, 1961)—Henry H. Tift, Macon (December 30, 1962)
AMA Alternate Delegate (term beginning January 1, 1961)—W. G. Elliott, Cuthbert (December 30, 1962)
Ninth District Councilor—Charles Andrews, Canton (1963)
Ninth District Vice Councilor—Paul Scoggins, Commerce (1963)
Tenth District Councilor—Addison Simpson, Jr., Washington (1963)
Tenth District Vice Councilor—M. A. Hubert, Athens (1963)

Immediate Past President Luther H. Wolff then

turned the gavel over to President Milford B. Hatcher for installation of these officers.

President's Key

President Milford B. Hatcher then presented the President's Key, and a bound copy of the *Journal* for the year 1959-60 to Immediate Past President Luther H. Wolff in appreciation for his untiring and diligent service to MAG. Dr. Wolff responded with appreciation to Local Arrangements Chairman, Simone Brocato, Auxiliary Arrangements Chairman Mrs. Theatte, and all of Columbus for a grand 1960 Annual Meeting.

Site of 1962 Annual Session

President Hatcher then announced that the site for the 1961 Annual Session had been previously set for Atlanta, Georgia, and he called for invitations for the site of the 1962 Annual Session of the MAG. T. A. Peterson, representing the Georgia Medical Society, invited the Medical Association of Georgia to convene in Savannah. This invitation was accepted with appreciation on motion duly made and seconded.

There being no further business, President Hatcher adjourned the *106th Annual Session of the Medical Association of Georgia held in the Municipal Auditorium, Columbus, Georgia, on May 1-4, 1960 at 12:00 noon.

Luther H. Wolff, Columbus, Immediate Past President (far right) installing new officers of the MAG. Starting at the left, they are: Milford B. Hatcher, Macon, President; Fred H. Simonton, Chickamauga, President Elect; Simone Brocato, Columbus, First Vice President; Braswell E. Collins, Macon, Second Vice President; John T. Mauldin, Atlanta, Secretary, and Dr. Wolff.



NEW MEMBERS OF THE MAG

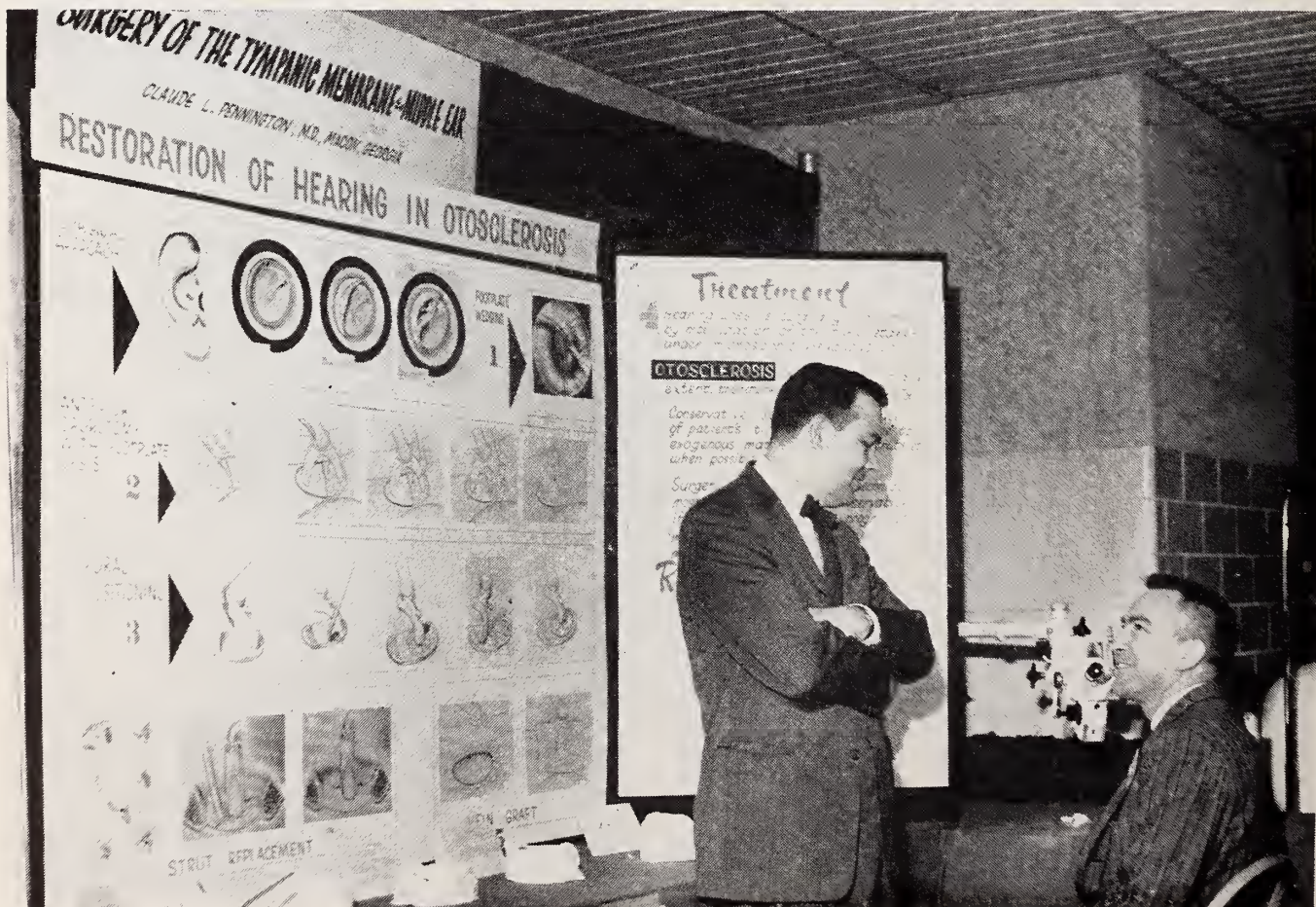
<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Arkin, Murray C.	121 E. Jones St. Savannah	Active	Georgia Medical Society
Baskin, John H., Jr.	80 Butler St., S.E. Atlanta 3	DE 2	Fulton
Beasley, Carroll	57 Main Street Savannah	Active	Georgia Medical Society
Bonner, Mack S.	4414 Abercorn St. Savannah	Active	Georgia Medical Society
Bridges, Wm. H.	Johnson Street Dawson	Active	Randolph-Terrell
Brooks, Charles P.	103 S. Main St. Conyers	Active	Newton
Brown, Calvin A.	106 Lawrence Street Marietta	Active	Cobb
Brown, Charles H.	Emory University Atlanta 22	DE 2	DeKalb
Burnham, James W., Jr.	1923 Jeffersonville Rd. Macon	Active	Bibb
Eilers, Robert W.	Oakdale Clinic, Rt. No. 1 Smyrna	Active	Fulton
Fulghum, Charles B., Jr.	Emory University Atlanta 22	Active	Fulton
Gordy, Martha C.	13 Medical Arts Center Savannah	Active	Georgia Medical Society
Graves, Edward M.	Medical Arts Clinic Toccoa	Active	Stephens
Guerrieri, Louis R.	Emory University Hospital Atlanta 22	DE 2	Fulton
Harbour, John H.	Cherokee Medical Bldg. Marietta	Active	Cobb
Hinton, Golden S.	220 N. Milledge Ave. Athens	Active	Crawford W. Long
Leopold, Louis P.	9 E. Gordon St. Savannah	Active	Georgia Medical Society
Newberry, Dan C.	80 Butler St., S.E. Atlanta 3	DE 2	Fulton
Reeves, Seab E. A.	80 Butler St., S.E. Atlanta 3	DE 2	Fulton
Robertson, Mason G.	24 E. Liberty St. Savannah	Active	Georgia Medical Society
Sams, Bruce J., Jr.	304 E. Huntingdon St. Savannah	Active	Georgia Medical Society
Schiff, Gilbert M.	P. O. Box 185 Chamblee	DE 2	Fulton
Sella, John L.	380 W. Ponce de Leon Ave. Decatur	Active	DeKalb
Suit, Ivory	City-County Hospital LaGrange	Active	Troup
Sweat, Maxwell J., Jr.	121 Oglethorpe Ave. Albany	Active	Dougherty
Vanderburgh, Alexander	University of Georgia Athens	Active	Crawford W. Long
Warren, Cecil D.	2010 S. Lumpkin St. Athens	Active	Crawford W. Long
Williams, Jack B.	University Hospital Augusta	Active	Richmond
Wolfe, David M.	400 Highland Ave. Albany	Active	Dougherty



Past, Present, and Future Presidents of MAG. From left to right, Fred H. Simonton, President Elect; Milford B. Hatcher, President, and Luther H. Wolff, Immediate Past President.

CANDID CAMERA AT THE

Joe Pennington, Macon (standing) and Harold S. Engler, Augusta (sitting) discuss the First Place scientific exhibit entered by Dr. Pennington.





Chris J. McLoughlin, Atlanta, presents Certificate of Appreciation to Mrs. Remer Y. Clark, Marietta, Immediate Past President of the Woman's Auxiliary to the MAG.

J. G. Standifer (right), Blakely, receives "G. P. of the Year" award from Fred H. Simonton.



Luther H. Wolff presents "Distinguished Service Award" to Enoch Callaway (right), LaGrange.

***105th ANNUAL SESSION**

J. G. McDaniel (right) presents Fifty Year Certificate to Carl C. Aven, Marietta.



DOCTOR, DO YOU REALLY WANT SOCIAL SECURITY?

Luther H. Wolff, M.D., F.A.C.S., *Columbus*

DO YOU, AS A physician, know that under Social Security you:

1. May pay the equivalent of \$35,000 without getting any return whatsoever?

2. May get under private commercial insurance better protection for your dependent children for less than half what such protection costs you under Social Security?

3. May leave your widow to subsist for decades with no benefits being paid under Social Security?

4. May get better disability benefits under private insurance than are provided under Social Security for less money?

5. Have to have paid taxes into Social Security for at least five years at present, and up to ten years in the future, before you are eligible for retirement or widow benefits?

6. Can draw no benefits if you continue to work until you reach the age of 72? Can only draw a net of \$1,200.00 per year in benefits after age 72 if you continue to work and gross as much as \$4,800.00 a year?

7. Can look forward to paying substantially more Social Security Taxes in the very near future due to the inevitability of raises in the ceiling from \$4,800.00 to an indeterminate amount?

8. Turn over to a federal bureaucracy your freedom of choice in attaining your own desires and goals?

These are a few of the unpalatable facts and possibilities that you as a physician will encounter if you are included under Social Security.

Social Security for physicians is objectionable to physicians on three counts, viz.: moral, philosophical, and economic. Disregarding temporarily the moral and philosophical concepts involved, let us examine and analyze the economic aspects of Social Security presently in force.

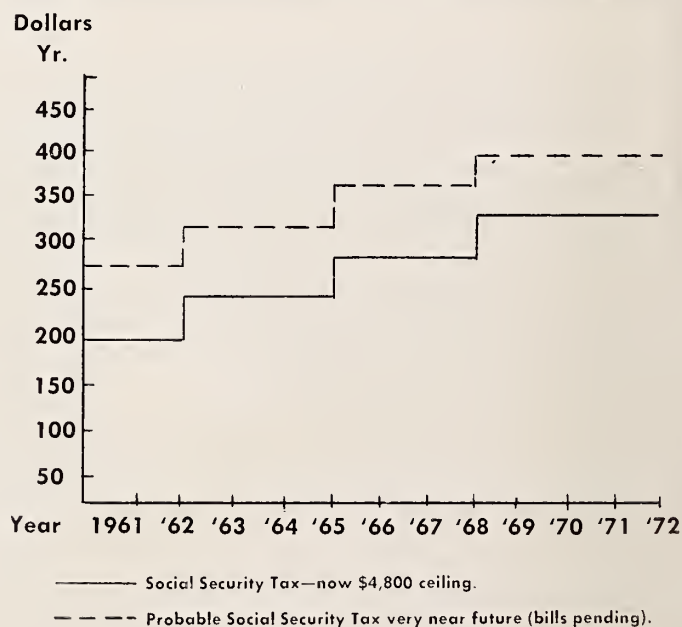
An analysis of Social Security shows that this program is, in fact, a hodge-podge of so-called "insurance." Certain phases of it are mutually exclusive. For example, if you live to collect retirement benefits, you obviously are unlikely to obtain bene-

fits for dependent children; conversely, you cannot collect retirement benefits if you are so unfortunate to obtain benefits for dependent children. Yet part of each tax payment you will make goes to each phase. You have no choice under Social Security to select the type of insurance best suited to your needs and goals. Your estate has no equity in the money you will have paid in.

Phases of the Social Security Program

Now, let us look at what the Social Security Tax is now and what it will be in the near future. (Graph I) You will note that the present tax rate jumps

Graph I
Cost of Social Security

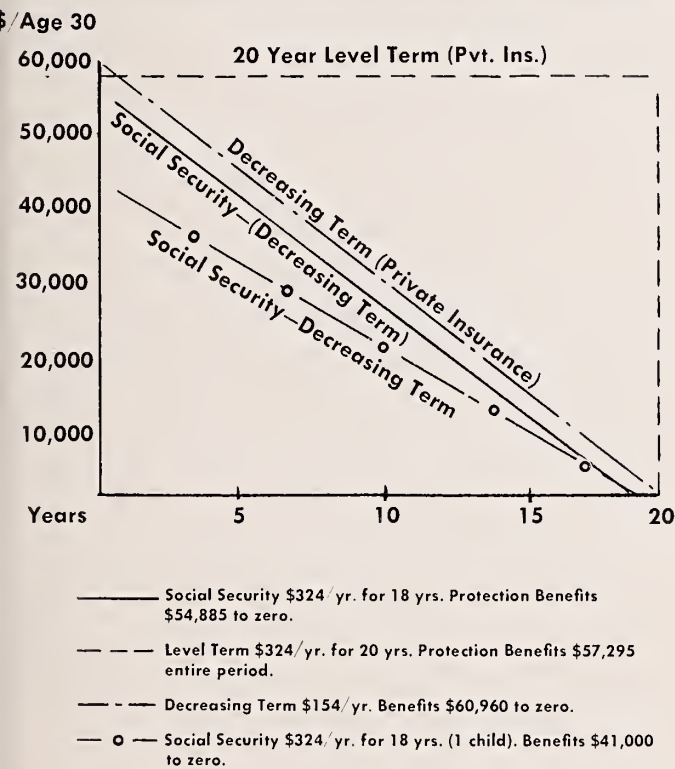


three-fourths of one per cent every three years through 1968, when it presumably (no guarantee) will level off at \$324 per year. Social Security attempts to cover four phases of an individual's life: (1) dependent children (no more than two) and wife while children are dependent; (2) disability after age 50; (3) widows benefits after age 62, and (4) retirement benefits after age 65, if you retire, but none until age 72 if you earn more than \$100.00 per month.

Phase I—Dependent Children

As far as I can determine, a physician's primary concern is to provide for his wife and children in the event of his death or disability. The average physician, if he can keep working a normal life-time, will be able to provide security for his wife and himself much better than that provided under Social Security. Therefore, let us see how selective and planned private insurance compares with Social Security. (Graph II)

Graph II
Comparison of Private Insurance
Coverage with That Provided
Under Social Security



In tabular form, Graph II is summarized below:

Age 30:	Social Security	20 Year Level Term	20 Year Decreasing Term
Cost	\$324 year	\$324 year	\$154 year
Years	18	20	20
Waiting Period	18 months	None	None
Maximum possible benefits, total, 2 or more children	\$54,104	\$57,295	\$60,960
Benefits end of 10 years	\$24,045	\$57,295	\$30,480
Benefits end of 18 years	None	\$57,295	\$6,096
Maximum possible benefits if 1 dependent child	\$41,169	\$57,295	\$60,960
Maximum widow benefits, alone	None	\$57,295	\$60,960

The above Term Insurances include waiver of premium.

It will be noted that the decreasing term insurance (cost \$154 per year at age 30) closely parallels the decreasing term "insurance" of Social Security (cost

\$324 per year) except that the former insurance offers a tremendous advantage for the widow with no dependent children or with one dependent child. At age 40, a 10 year level term insurance can be purchased for a net of \$8.32 per \$1,000 insurance. You may purchase \$39,000 of Level Term Insurance with the \$324 per year which you will pay into Social Security. This will cover your wife regardless of whether or not you have dependent children. (Remember Social Security pays only if there are dependent children under 18 years of age, and only until they are 18.) Any of these term insurances can be converted to other type policies (straight life, annuity, etc.) with no physical examination being required.

The variety of insurance options obtainable are many. For example, you can purchase Level Term Insurance to cover your dependents until you are aged 65 to the amount and at the premium specified below, all with waiver of premiums:

Age Obtained	Amount of Insurance	Cost
30	\$31,000	\$329 year
40	\$22,000	\$327 year
50	\$14,000	\$320 year

Or, you may elect to take a 20 year level term insurance at the cost of \$240.46 a year at the age 30, which will guarantee to pay \$253 a month for 20 years to your survivors or heirs after your death, provided you die within the 20 year period. For the amount of \$84.00 per year (the difference between the cost of the above insurance and that of Social Security) you can take a 20 year deferred survivorship annuity which at the end of the \$253 a month payments, will guarantee to pay your wife \$150 a month for life.

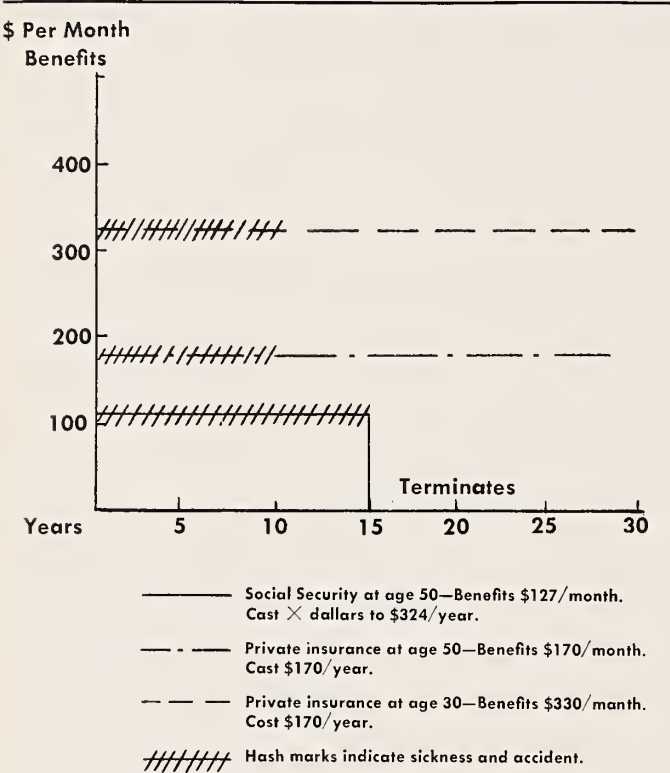
From the above, it is very clear that the term insurance from private companies is far superior to the "term insurance" offered under Social Security for protection of dependent children. The advantage for your wife is even greater. Remember, your wife gets nothing until she is aged 62 unless there are children under 18. This explains how your wife may have to subsist for decades with no benefits being payable under Social Security, even though you may think you are "covered."

Phase II—Disability

The other phase of insurance that concerns physicians is that of total disability. Under Social Security you do not get disability benefits until you are at least aged 50 and have been disabled six months. You must be under Social Security for at least five years, and, through graded steps, ten years by 1971, before you are eligible for these benefits. If all these

conditions are met you are then entitled to \$127 per month. (Graph III)

Graph III
Comparison of Disability Benefits
Private Insurance — versus — Social Security



Let us suppose that you are satisfied to be covered by the 20 year decreasing term insurance at a cost of \$154 per year (similar to Social Security payments). For the extra \$170 a year you save over the Social Security payments you can, at age 30, purchase disability insurance (must be disabled also six months) which will pay you \$330 a month for ten years if disability is due to illness, and \$330 a month disability for life if due to an accident. At aged 50 you can purchase for the same amount, and under the same conditions, insurance that will pay \$170.00 a month for ten years of illness disability, and \$170.00 a month for life for injury. As physicians, we know that there are very few illnesses that totally disable one for more than ten years,—either one recovers or one dies.

Phase III—Widow Benefits
After Age 62

This phase, and phase IV, are actually annuity benefits, and should be viewed accordingly. Under Social Security your widow is entitled to \$95.30 a month at age 62, if she doesn't work. No provision is made for widows before this age unless dependent children are in the picture. A physician can purchase

life insurance to the amount of \$19,513 at age 30 at a cost of \$407 a year, which, under one of the options available, will guarantee his widow \$100 a month for life at age 60. Moreover, if he dies at any time after payment of the first premium, his widow will receive \$54.44 a month until she reaches age 60 when the \$100 a month payments begin. Waiver of premium is included in the premium. There are various other options and annuities available which may prove far superior for the financial protection of your widow than the protection she will obtain under Social Security.

It must be considered in your evaluation of the situation, that you must have paid Social Security taxes from between five to ten years before your wife becomes eligible for *any* widow benefits under Social Security. Actually, the average physician's wife can do very well without the \$95.30 a month paid by Social Security provided that the physician is able to practice constantly from age 30 to age 60 or thereabouts.

Phase IV—Retirement Benefits

Social Security retirement benefits *are not* planned for the self-employed physician. Statistics show that only between 10 per cent and 15 per cent of private practitioners of medicine retire before the age of 72, and many physicians continue to practice well beyond this age. This, therefore, is the greatest objection to coverage of physicians under Social Security. It is patently the most unfair phase.

You can, as a physician, pay the equivalent of \$35,000 into Social Security (\$324 a year from age 30 to age 72, which, if paid into any fund at four per cent semi-annual compound interest, will amount to \$35,686.) If you work until your terminal illness at age 72 or thereabouts, and your wife predeceases you, the total return from Social Security your estate may obtain is a single \$255 death payment. It seems certain in the overall picture that many more physicians will fall into or near the above category than will benefit materially from the other phases of Social Security.

Assuming that you live beyond age 72 and continue to work and to gross as much as \$4,800 a year, you will receive \$127 a month benefits or \$1,524 a year—out of which you will have to pay \$324 Social Security Taxes a year—netting \$1,200 a year. If you invest the \$35,686 at four per cent interest which you might have accrued (\$324 a year at four per cent compound interest during the past 42 years) you can net \$1,727 a year or \$144 a month versus \$100 a month under Social Security. Then the \$35,686 principal would be a tidy nest-egg for you if needed; no such nest-egg is available under Social Security. Your wife will applaud your gener-

osity if you should predecease her leaving her some such sum as above rather than the strictly limited \$95.30 a month payable under Social Security.

Here again it is necessary to keep in mind that you must be under Social Security for from five to 10 years before you are entitled to even the above benefits.

Assumed and Accepted Errors

In analyzing Social Security for physicians, where there have been somewhat complicated mathematics involved, I have assumed that all physicians will gross at least \$4,800 a year. Also, in these mathematical exercises, I have assumed that the basic yearly rate to physicians is \$324, when, in fact, it does not reach this level until 1969. The difference involved (\$432) does not materially effect long range results.

Most of the analyses are based on the physician being aged 30. It is not denied that in some instances, especially in regard to the widow and retirement benefits, that a physician in the age bracket of 50 to 60 might gain some slight advantage under Social Security over the security he might obtain from private purchase of annuities, etc. However, if physicians *are* included in Social Security it will not be many years until *every* physician will start paying in the 30 year old range. Surely, no honest, ethical physician would be guilty of advocating this measure for his future confreres in order to obtain some slight advantage through strictly selfish motives!

Random Observations on Social Security for Physicians

1. There is no recall or reconsideration under Social Security—once in, always in.
2. Social Security taxes are *not* deductible items from income, either state or federal.
3. There is no contract involved between you and the government under Social Security. You can be taxed any amount that Congress sees fit to apply. As in all welfare state projects, the trend is inevitably and inexorably upward.
4. Significantly, the only large group of people, other than physicians, *not* presently covered under Social Security are governmental employees, *including* members of the U. S. Senate and the House of Representatives.

Socialistic Propaganda

Unfortunately, the "Physicians' Forum," a leftist New York organization that has enthusiastically and publicly endorsed the Murray-Wagner-Dingle bill, the Forand bill (HR 4700), and other socialistic measures, is working strenuously to get physicians to accept Social Security. It has a Committee working under its socialistic aegis called "The Committee on Social Security for Physicians." The "Committee" has flooded the members of the medical profession with literature extolling the virtues of Social Security with false propaganda and half-truths that tend to delude the busy practicing physician into falling into this socialistic trap. That they have tragically succeeded among the rank and file of unwary physicians is attested by various state polls advocating inclusion of physicians under Social Security.

If each physician, before he votes on this matter, would study and analyze the material contained in a pamphlet entitled "Your Social Security" found in any Social Security office, and compare the benefits with those obtainable under private insurance, the results of such polls, I am confident, would be very different.

Ethical and Philosophical Concepts

Physicians are, and have been, strong advocates of freedom of choice. That one physician or group of physicians, at the expense of individual liberty and dignity, should compel his fellow physician to accept governmental regulation and control of a matter so personal as the financial welfare of himself and his family, is an insult to the intelligence of his colleague. Surely, each physician is capable of determining best what his needs are, and providing for them accordingly.

The Forand bill is, pure and simple, merely an extension of Social Security. How, then, can physicians oppose this measure on the one hand, and at the same time extend the other hand in supplication for the "benefits" of Social Security? The incongruity of such a position is obvious.

It is time for physicians to alert themselves to this unwanted proposed legislation, and to oppose strenuously such measures! Even now this legislation is in the legislative hopper!

Medical Arts Building

Insurance data were furnished by Mr. Arthur N. Berry, Jr., Columbus, Georgia, a representative of the Massachusetts Mutual Insurance Company. Many grateful thanks are extended to him.



MEDICAL AND HEALTH CARE FOR THE AGED

Hon. Thomas B. Curtis, *St. Louis, Missouri*

MR. CURTIS OF MISSOURI: Mr. Speaker, yesterday I placed in the Appendix of the *Record* at page A2634 a speech that I gave before the American Academy of General Practice at Kansas City, Mo. Three weeks later, I gave the same speech before the convention of Missouri Insurance Agents in St. Louis, Mo.

As I stated, when I placed this in the *Record*, I prepared the speech to be delivered to these seemingly diverse groups. In this speech, I discussed the general background of the problem our society faces on medical care and hospital care for the aged. I expressed the belief that the tremendous progress made in our American society in advancing the well-being of all our American citizens had made ineffective the demagogery which was based on using the Federal Government as the means of transferring wealth from the "haves" to "have nots." . . .

Forand Bill

Now let us discuss the Forand bill. Does it really assure real health progress to retired citizens as the three-penny post card, mass produced by the COPE, states? Or will it damage the progress we have made?

I think it will do damage, that it will throw us backward, and thwart the progress we have made. This is the issue. The issue should not be to get votes; it should be what program is best for our aged citizens and for our society as a whole.

H.R. 4700 would, if it became law, provide the 11 million persons eligible for OASI benefits and their 4,000,000 dependents and survivors with up to 60 days of hospital care, a limited amount of nursing home care, and certain surgical benefits. Sufficient money to pay for this ostensibly would come from an increase in the OASDI payroll tax of one-quarter of one per cent on the employee, and an equivalent amount on the employer.

But the proposal is discriminatory and neglects a sub-

stantial group of our aged.

There are, for example, almost 2,000,000 men and women on old age assistance who would not be benefited by H.R. 4700.

And there are 2,500,000 persons over 65 who are not receiving either OASI or OAA, and who are not currently eligible for OASI. H.R. 4700 would not benefit them either. Seven years ago I sponsored legislation which is now law to permit the retired people who were not covered under social security to receive the benefit of a retirement income credit against tax to equalize the situation between persons receiving and not receiving social security benefits which are tax exempt.

Many of these people not on social security have lower cash incomes, on the average, than the incomes of those who receive monthly OASI benefits. These are the people who are most apt to have severe financial difficulties in paying their health care costs.

Putting it another way, the persons really in need would derive no benefit whatsoever from the passage of the Forand bill.

Four million people over 65 are either employed, or wives of employed persons, and presumably are able to meet the costs of health care as well as they ever were. This represents nearly 25 per cent of the total older age population, and includes many active workers employed in companies with group health insurance plans.

Limited Benefits

To sum it up, then, H.R. 4700 would do nothing for those who need it most; and would take no account of the fact that millions of Americans don't need the limited benefits the measure proposes. But it would not cover everybody who is eligible for disability benefits, nor would the measure provide for payment to mental or tuberculosis hospitals.

In the group that would not benefit, I might state, are our retired teachers and many people who retired on other pension programs and who are not included in social security, primarily because they were born

Representative Curtis presented this speech to the House of Representatives, Thursday, March 24, 1960.

too soon to be covered under the social security program. These people would be completely without benefit from the proposals in the Forand bill. As I previously explained, seven years ago I sponsored legislation which is now law to permit the members of this age group—our teachers in particular, although there are many others who are retired on pension programs other than social security—to exclude from their income the appropriate amount equivalent to the social security benefits that the social security beneficiaries are receiving.

I point that out as one individual Congressman who has been concerned about the problems of the aged and who has done something in their behalf by action such as the retirement income credit because that is now the law and our people have been receiving the benefit of it for many years.

As I have stated, the persons really in need would derive no benefit whatsoever from the passage of this bill. H.R. 4700 would do nothing for those who need it the most.

Indigent Provided For

Those who favor the Forand type of legislation limited, as it is, to this one aspect of our aged citizens, reason from these following premises:

(1) The aged are too poor to pay for their medical care, although their medical needs are greater than those of any other age groups.

Incidentally, there is one point that should be driven home. No indigent, no poor older person in America today lacks adequate hospital or medical care if he seeks it. In other words, our Community Chest agencies, our welfare programs, are taking care of the indigent. The problem is not the indigent in this particular situation. It is those who can afford to pay, those who have limited means, and those who are confronted with a catastrophic illness who find themselves in a serious plight.

(2) The second argument advanced by those who favor the Forand type of legislation is that the aged cannot get private health insurance or, if they can, the insurance is inadequate.

(3) The third argument advanced is that these problems can be solved simply by extending the social security system into the field of health care.

Before examining these assumptions and seeking to determine their validity let us look briefly at some of the general aspects of the aged people. The Social Security Act has arbitrarily defined "old age" and despite the fact that old age is relative and based upon physiological changes, the Social Security Act bases it upon birthdays—65 for a man and 62 for a woman.

By this standard there are now some 15.5 million Americans over 65 who can be called aged. This group is living evidence that we have the finest system of scientific medicine in the world and that our standards of life are unparalleled in history.

Each year our older population will increase, and by 1970 this fortunate Nation can expect to have 20 million people over 65. But the growing number of these aged have to some extent caught us unprepared. For example, we are only beginning to understand the

waste of human resources involved in the arbitrary retirement of these people because of their chronological age.

I might say, one of the greatest needs in the area for reform in the social security law today is the clause that does not permit these people to engage in employment and receive their entire social security benefit entitlement if they earn more than \$1,200 a year.

And so far as these people I have been mentioning are concerned—Mr. Reuther and the organization COPE—they are the ones who have consistently resisted any liberalization of this work clause because, as they say, they want these people out of the labor market. The point I am making is this: If the COPE representatives are interested, as they now claim to be—all of a sudden, I might say—in the welfare of the aged people, why do they not direct their attention to this problem of the OASI retirement test? There is no question that if we liberalize the amount of earnings allowed, we are going to have to increase the social security tax. It is simply a question of whether or not the good that we could do by increasing the amount that a person can earn and still stay on the social security rolls will be equivalent to the social good that comes from the cost that we would have to pay through additional social security taxes. That is one of the difficult problems with which the Committee on Ways and Means has to grapple in this area, because we cannot just be Lady Bountiful and say that we love the people and that we will give them everything. We are the ones who have to face up to the fact of where do we get the money, and from whom do we take the money? And, we will be taking the money from the American people.

So millions of men and women, many as capable as they were at 40, are shelved long before they should be; long before they want to be. With retirement, cash income usually drops, and at the same time the need for health care services increases until today it is about twice that of the younger adult. It is this combination of lower income and greater need for health services that has led some well-meaning people to believe that medical care is the most critical problem besetting our aged population. In their opinion, apparently, only the Federal Government can provide an adequate answer.

Misleading Statistic

Against this background let us examine the premise upon which the supporters of H.R. 4700 base their arguments. Although the health needs of our older people may be greater than those in other age groups, are the aged too poor to pay for their own medical care? The answer is that some are, but the overwhelming majority are not. We are told—and the gentleman who preceded me used these figures—that three-fifths of all people over 65 have less than \$1,000 per capita annual income. Although in one sense this is an accurate statistic, it would be hard to find a more misleading statistic. It is equally accurate and just as misleading to state that in 1957, the most recent year to which that misleading figure applies, 66.7 per cent of all Americans had incomes of \$1,000 or less per year. In 1957 almost half of these persons over 14 years of age also had incomes of \$1,000 or less per year, and 47 per cent

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of those between the ages of 14 and 65 had incomes below \$1,000 a year.

Let us just illustrate this. Suppose we organized a social club with only two requirements for membership, (1) that no wives had incomes of their own and (2), that all husbands earned at least \$25,000 a year. If we use the same statistical techniques as those employed in compiling the figures of three-fifths of all our people 65 and over have less than \$1,000 annual income, we could come up with this statement that half the members of this social club have incomes of less than \$1,000 a year. Obviously the money income figure cited by the Department of Health, Education, and Welfare for those aged 65 and over is of little help to us in considering the financial problems of the aged. Income drops after retirement, yes, but no age group is likely to have as favorable a liquid asset position as the aged, 74 per cent of whom now own liquid assets of one form or another. Furthermore, the needs of the aged person are usually less; the heavy expenses of raising a family are behind; for the most part homes are paid for. In fact, according to the OASI, almost three of every four beneficiary couples own their own homes; most of them free of mortgage. And the median equity in nonfarm homes for the homeowner was \$8,360; and add to that the household effects and so forth.

Only four per cent of the aged live in the homes of relatives. A survey in 1957 by the National Opinion Research Center determined that only 9.6 per cent of those interviewed would be unable to pay a medical bill of \$500.

Financial Resources

So when we consider the financial resources of the aged, we can do it sensibly only if we know how many have income from employment, social security, pensions, annuities, savings, investments, insurance, and other assets. We can only measure financial resources intelligently if we consider them in terms of family income and assets, not individual income and assets.

Then note the figures used, \$1,000 per capita when many of these people, in fact I think the majority of them, are couples. So per capita immediately becomes \$2,000 per married couple. And when we attempt to figure out the number of people who cannot afford adequate health care we must know how many already receive it from a religious group, fraternal group, through membership in a union, as ex-seamen, and as members of the Armed Forces.

And what an unfair reference to President Eisenhower the gentleman from Pennsylvania made, because President Eisenhower received all of that as a member of the Armed Forces. We in the Congress have felt that that was a proper and just thing to do.

There are those who receive benefits as professional courtesy, as members of specific religious orders, and as veterans entitled to compensation and care.

We know, for instance, that 16 per cent of the aged are public welfare recipients. As such under federally aided public funds program, they are eligible to receive medical care and do receive it.

We do not know the answers to questions these facts

pose. Here are some things we have got to know. How much do the families of the aged help out? And how many of our older people are affluent or rich?

No Real Guideposts

My point is that the economic problems of older people are not only complex and diverse but difficult to analyze precisely. Yet it is suggested that we take a serious and irreversible legislative action with tremendously important consequences, with no real guideposts.

We are being asked to grope our way through the statistical darkness on the off-chance that we will stumble into an effective solution. No one denies that there are instances of severe hardship among our older people or among any other age group, for that matter. Such cases do exist, although to what degree we can only guess. One of the great things about the social security bill that I believe our committee is going to bring out is that we are paying attention to a very serious problem involving a group of people who are totally disabled, who are below the age of 50. If you are totally disabled, it does not matter whether you are 24 or 55 or 65 or 75. That is an area to which we are directing our attention and that is an area in which I believe the Committee on Ways and Means will present some affirmative legislation to the House. That is an area, I might state, to which the administration has been giving attention.

Certainly the weight of all the evidence seems to suggest one conclusion. The financial and health problems of the aged have been considerably exaggerated by the proponents of the Forand type of legislation, and on the basis of the facts as we presently know them, it is impossible to justify the creation of a massive Federal mechanism for compulsory national health insurance, even though the mechanism would deal only with a single and somewhat artificially determined category and one segment of our aged population.

Implicit in the thinking of those who support H.R. 4700 is the belief that the health care needs of older people can be conveniently separated from their other needs. Nothing could be a greater mistake. Some of our aged have many needs; housing and recreation; in preparation for retirement; in finding acceptance and understanding within the community; in developing new interests; in using talents and capabilities; and in seeking love and affection.

As an example of how interrelated the needs of the aged can be, a former housing commissioner of the State of New York has pointed out that hospital confinement of older people could be reduced by 20 per cent if adequate housing were made available for them.

Help for Nursing Homes

How many Members of Congress realize that last year this Congress passed in the housing bill one of the greatest features to ameliorate this very problem of helping the aged. We made FHA-type loans available to private nursing homes. I may say to those who like to criticize the American Medical Association that they helped sponsor that legislation. I was the main sponsor. I went to them and asked their help on it because, I

said, this area of facilities for good, adequate, safe private nursing homes is one of the greatest needs of the aged people.

Furthermore, if we could get these private nursing homes we could cut health costs considerably, because the old people in many instances do not have to go to hospitals. The nursing home, which is the facility they really need, costs one-tenth of what a hospital costs. If we can build nursing homes of one floor instead of renovating old mansions of three or four stories we can cut the cost to the aged in that type of modern, up-to-date private nursing home facility.

Genuine Progress

So there are things being done. Just because there is not a propaganda machine reporting this genuine progress, there is no reason for our people to think that nothing is being done.

Further, the Nation's doctors have repeatedly stated that no person regardless of illness needs to forego a physician's service because of inability to pay. Expert medical testimony before the House Ways and Means Committee established another point. The aged have more than just individual health needs. As Dr. Frederick C. Swartz told the Ways and Means Committee:

Care for any segment of our population—the aged included—calls for a cooperative attack on the problem by nurses, doctors, hospitals, social workers, insurance companies, community leaders, and others. It requires flexibility of medical technique—an ingredient which would unquestionably vanish the moment Government establishes a health program from a blueprint calling for mass treatment . . .

In the case of the aged, their health problem primarily involves acute illness and the so-called degenerative diseases. In a very large percentage of cases, the main need is not for an expensive hospital stay or a surgical operation, but for medical care at home or in the doctor's office.

How many Members have heard of the Visiting Nurses Association? I was the only male member for a good many years of the Board of Directors of the Visiting Nurses Association in St. Louis. It involved the technique of teaching people how to care for people, old people particularly, in their homes, so that they do not have to go to a hospital or even to a private nursing home.

In other cases, the important requirement is nursing care in the patient's home, or the home of relatives. And in still others, custodial care in a nursing home or public facility may be the only answer. The point is that the medical needs of this particular segment of the aged are subject to countless variations.

Private Insurance Effective

The Forand bill wishes not only to assist the aged population who do not need the greatest amount of assistance, but it wants to move the Federal Government into the very area of medical care where private insurance is now most effective, the area of hospitalization and surgery.

H. R. 4700 is, therefore, like a salvo of grapeshot fired at a smoke-shrouded target. It would apply to only aged persons under social security, but it would apply to them whether they needed help or not, whether they wanted help or not, and whether or not they could use

the sort of help the bill undertakes to provide.

Just as you would expect from a volley of grapeshot, most of the ammunition would be well off the aiming point—if, indeed, there is one.

Let us examine the second premise of the bill's supporters—that the aged cannot get private health insurance, or that if they can, their insurance is inadequate.

The record disproves this completely. The growth of private health insurance during the past 25 years—I would say the past 10 in particular—has been phenomenal. Today, 127 million Americans are covered, and it is significant that the amount of health insurance owned by aged people is growing at a rate faster than that of the population as a whole.

Private health insurance is not available to the aged? Here is the answer: There are now 37 Blue Shield plans in 34 states which offer coverage for the over-65 age group. In all but three instances, there is a companion Blue Cross plan as well.

An additional 16 Blue Shield plans, in 11 other states, have over-65 programs in various stages of development.

And more than 125 private health insurance firms—some of which are licensed in all states—offer coverage to the aged.

Benefits for Aged

Health insurance benefits for the aged are provided in a number of different ways. Older active workers are, without exception, continued in group insurance plans. Most new group plans provide for continuation of benefits to retiring workers. Other group plans allow the retiring worker to convert his protection to an individual policy. Several insurers are now issuing group plans to such associations of older people as Golden Age clubs.

Most insurers continue into the later years individual contracts issued at younger ages. And contracts especially designed for older people do not require evidence of good health as a condition of eligibility. In fact, after a short probationary period, benefits are paid for loss due to preexisting conditions.

Much of this is quite recent. I may say one of the companies just started out in 1957 with a supplemental plan in Iowa, and immediately next year it extended to four additional states in 1958. In 1959 it extended to 10 additional states and 17 additional municipal or metropolitan areas, and in the year 1960 it looks as if the extension is going to be in 20 states. The point I am getting at is that a great deal of this is quite recent, but this whole program has been done almost within the past 10 years.

Finally, there are some insurers who offer health insurance contracts that become paid up at age 65.

This wide diversity of plans reflects free competition among many insurance companies which vie with one another in the effort to provide ever more adequate benefits through more efficient methods.

As for the benefits available to the aged under private health insurance, they are not significantly different from those offered to younger people.

In 1952, only 26 per cent of the older age group had some form of health insurance coverage. Today, more than 43 per cent—more than 6,000,000 persons—

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are protected against the cost of health care, with the number of insured rising more rapidly than for any other age group.

A recent study group estimates, and I have used the figure before, that by 1965 that figure of aged covered under health insurance will be 80 per cent of our aged population desiring and wanting health insurance to protect themselves. Mind you, in all of this discussion we are not talking about the poor. The poor are already taken care of. We are talking about people who can afford to pay if the insurance is available.

This growth reflects the steady expansion of the voluntary health insurance mechanism, which today provides a cushion against the financial impact of illness for nearly three out of four persons. It also reflects the intensive experimentation carried on by insurance companies, Blue Cross-Blue Shield plans, and other types of health insurance organizations toward broadening the availability and improving the quality of coverage for the aged.

Increase in Coverage

The increase in coverage of those 65 and over can be expected to continue. Better than 70 per cent of the total population today enjoy the benefits of voluntary health insurance.

Those who have had this protection during their working years value it, and can be expected to continue it after retirement.

This was not the case, however, with most of the present aged, who did not have this kind of protection during their working years.

The Health Insurance Association of America estimates that 65 per cent of the aged needing and wanting protection will be insured by the end of this year, and, as I have said, this percentage will increase to 80 per cent by the end of 1965, and 90 per cent by 1970.

Health insurance, like medical care, cannot be dispensed on a production line basis. Health insurance is written in many forms, by many types of insurers, and with a wide variety of benefits. It is this widespread choice, which allows the buyer to select the coverage best suited to his individual needs, that provides the workable alternative to the compulsory system called for by H.R. 4700 and other plans. On the one hand is coverage tailored to meet the individual's own, particular requirements; on the other is a rigid, single pattern of benefits which bills like the Forand bill would impose on everyone—rich or poor.

The choice is clear. The facts show that private health insurance is increasingly meeting the needs of the aged, as well as the needs of other segments in the population. To substitute a compulsory system of health insurance for a voluntary system of health insurance that has proved its ability and willingness to do the job is neither a responsible nor a sound decision, especially because in the very process of substitution, we would be contributing to the demise of private health insurance. This is not a question of adding the Forand bill because of what harm it would do. If we added that, we could not foresee this increased progress in the

area, and we would be going backward in solving the problem we are trying to solve.

For it is certain that those compelled by law to carry—at their own expense—the cost of national compulsory health insurance will neither be able nor anxious to carry private health policies as well.

There is the third premise of those backing such proposals as Mr. Forand's—that the health problems of the aged can be solved simply by extending the social security system into the field of health care.

As I pointed out, Mr. Speaker, these proposals fail completely to help matters for better than 4,000,000 people—those on old-age assistance, and those ineligible for OASI benefits. Yet this is the category of the aged population most likely to include the hardship cases.

Let us examine a number of other objections to these ill-conceived bills.

Assume, if you will, that we allowed the Federal Government to control disbursement of funds under such programs, as all of them specify; that we allow an agency of the Federal Government to determine the benefits to be provided; that this agency be given the right to set rates for compensation for hospitals, nursing homes, dentists, and physicians; that this agency be empowered to audit and control its expenditures to hospitals, nursing homes, and patients; and that this agency set and enforce standards of hospital and medical care—as indeed, it would be compelled to do.

Could the Federal Government assume these responsibilities—fiscal and otherwise—without affecting the quality of medical care which it dispensed? The answer is clearly that it could not.

The Government, in such a case, would undertake to provide a service purchased from outside sources. It is inevitable that Government would tend to control the purveyors of those services, for he who pays the fiddler calls the tune.

Government Control

The author of these bills disclaims that intention of meddling with the free practice of medicine. Just the same, if a single Government agency were placed in the position of buying perhaps 10 to 20 per cent of all care in the Nation's general hospitals, it takes no expert to see that this agency would possess great power to influence the operation and management of hospitals.

And possessing such power, no legislative restrictions this Congress could impose could prevent such a Government agency from wielding its power.

In the final analysis, the result of this would be that Government employees would, willy nilly, be telling the doctors what drugs and treatment they could provide; telling the hospital administrators how to run their hospitals; and telling the nursing homes what they could, and could not do.

Whether this is the intent of H.R. 4700 or not, this certainly would be one of its effects, for as the Supreme Court of the United States has observed, "it is scarcely lack of due process for Government to regulate that which it subsidizes." Indeed the Federal Government may properly be called derelict if it does not ride herd over the money it spends.

If Government pays the bill, Government will regu-

late the health care it buys with public funds.

There is the matter of unnecessarily overcrowding our hospitals, which are hard pressed as it is to cope with the demands for care of our rapidly growing population. Passage of the Forand bill would mean that our hospitals would be swamped, and our doctors overwhelmed by the increased improper use that would inevitably result.

If this is not predictable, then we have learned nothing from the experience of Great Britain, of Canada, and of other nations which have experimented with national health insurance. It follows, as the night the day, that people will seek to collect a benefit for which they are paying—regardless of whether they need it or not.

Individual Approach

The medical profession warns us that patients should be placed in hospitals, nursing homes, and other institutions only when necessary, and that the length of their stay, as well as the treatment they are given, should be governed by their medical condition, and not by the arbitrary limitations of legislation or regulations.

It is a warning that must be heeded. The relationship that exists between a doctor and his patient is an individual and private one. To disrupt it with the intruding presence of Government, to seek to substitute a collective approach for an individual approach to patient care—these are foolhardy actions.

Tax Increases

Let me comment briefly on the cost of H.R. 4700—present and future.

It is proposed that it be met by a tax of one-quarter of one per cent on the employer, one-quarter of one per cent on the employee, and three-eighths of one per cent on the self-employed.

Is that enough—even for now? Actuarial estimates by the insurance industry are that costs under H.R. 4700 would range from about \$2 billion to \$2.4 billion for the first year of the program's operation. By 1980, according to this expert opinion, costs would range from nearly \$6 billion to more than \$7.5 billion. And that would require a level premium of from 2.32 per cent to 2.97 per cent of taxable payroll.

That is a far cry from the tax presently proposed.

Beyond that, Mr. Speaker, I should like to remind the Members of Congress that social security taxes are already scheduled to reach nine per cent of payroll by 1969.

The Forand bill increases—whatever they worked out to be—would be in addition to the increases already provided for by law.

According to the Department of Health, Education, and Welfare, presently authorized OASDI benefits will cost us, by the year 2050, between 10.51 per cent of payroll—the Department's low estimate—and 15.96 per cent of payroll—the high cost estimated.

At what point will the taxpayers rebel? Some of them are now paying more in social security taxes than they pay in income taxes. And as time goes on, and more scheduled increases are put into effect, this trend will be intensified.

The proponents of this type of legislation are sug-

gesting, in effect, that we add to the tax burden, bit by bit, in the effort to determine how much the camel can bear.

I should like to remind them that a point can be reached at which one more straw will break the camel's back. And when that happens, we are apt to see the entire mechanism of social security jeopardized by public rebellion.

Mr. Speaker, bills like H.R. 4700 have no built-in rollback feature. They start small, as a rock slide will; and they end up as avalanches. Once a measure like the Forand bill becomes law, it is idle to wish it off the books; and once passed, no second-guessing will help.

Like Sinbad the Sailor's Old Man of the Sea, H.R. 4700 would cling to the shoulders of the American taxpayer generation after generation.

But if we passed this measure, would it remain in its present form? We would deceive ourselves to think so.

The Members of Congress would, thereafter, face continual demands for more—more expanded coverage, more elaborate benefits. And eventually, the thin end of the wedge having been duly inserted, we would reach the point where everyone—every man, woman, and child in the country—would be under a national, compulsory health insurance plan.

Many of the bill's supporters admit this openly. For example, I heard Mr. Walter Reuther of the UAW-CIO state, in testimony before the Ways and Means Committee last July:

It is no secret that the UAW is officially on record as backing a program of national health insurance.

To sum up, then, Mr. Speaker, although the corpse of socialized medicine was decently buried nearly a decade ago, it is dead but it will not lie down.

H.R. 4700 is a thinly disguised attempt to resurrect it and the manner in which it is being propagandized as a 1960 election issue demonstrates it.

Furthermore, H.R. 4700 is an effort to create an irreversible mechanism for solving what is, at worst, a temporary problem. Each year, more and more of those who reach retirement age are better equipped financially to live in self-sufficiency.

They are bringing with them, into the retired years, pensions, the health insurance of their choice, property, and a social security card.

We would do them real service if we worked to prevent the erosion of their savings and income by this ceaseless inflation, and if we searched for ways of easing their heavy burden of taxation.

Present Programs

I believe the present programs we have for medical and hospital costs for the aged programs in which the Federal Government plays a part—the state and local government play a part, the private employer, many of our unions, our community chests, our churches, our pious citizens who believe that the commandment "Honor thy father and thy mother" still has modern application, and the old people themselves, who as a matter of dignity want to provide for themselves, play a part, are all doing well. There are devices existing in our society which will solve the problems of the aged in the financing of health care costs in the immediate future. In the last 10 years there has been three times

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the progress in the field of health for the aged that there has been in the social security program as a whole, in 20-plus years it has been in effect. I believe our society can solve the problem of our aged as well as many other problems that no society has ever solved before. But we are not going to solve them unless we do a lot of hard thinking and a lot of work, and unless we eschew demagogery and do not throw the problem in a halfbaked manner into the political arena for the purpose of getting votes at one election.

We have ready at hand the device of public assistance—locally administered and locally disbursed, on the basis of known need. We have, ready at hand and hard at work, the voluntary efforts of civic, religious, and health leaders at the community level. We have, ready at hand and operating effectively, the machinery

of health insurance.

I suggest that we use them, if the evidence suggests that action must be taken.

But I remind the Members of this House that much evidence must yet be gathered. In the effort to get the complete facts, President Eisenhower has called the White House Conference on the Aging for January 1961. This Congress has appropriated approximately \$2 million for use in preparing for the conference.

We do need more information and it certainly would be premature to consider any action until we have analyzed the more conclusive and complete information which is being gathered and will be presented next January.

To tamper with a system of private medicine that has made this the healthiest Nation in history would be rash; for if we legislate in haste, we shall repent at leisure.

HEALTH CARE FOR AGED — MAJOR ISSUE

POLITICS NOW OVERSHADOWS all other factors in the issue of health care for the aged.

It appears certain to be a major issue in this year's campaigning for the White House and Congress, regardless of what Congress does in the field before adjourning this summer.

Both the Democrats and the Republicans are supporting costly, sweeping plans which differ on the basic approach. The major Democratic plans call for use of the Social Security System. The Republican proposals would have the Federal government and the states put up hundreds of millions of dollars to help the aged buy health insurance on a voluntary basis.

The medical profession and allied groups oppose these political solutions because, among many other important reasons, they actually would not meet the problems of many aged who need help in financing the cost of illness.

Meanwhile, a key Democrat—Rep. Burr Harrison of Virginia—warned Congress against acting on such legislation in this year of a national election. He predicted that if any such legislation should be approved this year, it “would be certain to be a monstrosity.”

Noting that various solutions had been proposed, Harrison said:

“The only features which these proposals have in common are that they are tremendously expensive; they all propose revolutionary change, and they are all complicated, uncertainly-based, and little-understood by the prospective beneficiaries.”

Harrison, who is a member of the House Ways and Means Committee which handles such legislation, urged that Congress defer action until next year. He recommended that, in the meantime, the Ways and Means Committee “conduct an exhaustive study of the various proposals.”

In early May, the Eisenhower Administration unveiled a Federal-state, \$1.2 billion-a-year plan to help the aged with limited incomes buy broad medical and hospital insurance coverage. Under the plan, an aged

person—if able financially—would bear part of the cost of both the insurance and of the medical care and hospitalization.

Arthur S. Flemming, Secretary of Health, Education, and Welfare, and Vice President Richard M. Nixon stressed that participation by the aged in the Administration program would be on a voluntary basis.

The Administration's plan immediately ran into widespread opposition. Dr. Louis M. Orr, Orlando, Fla., President of the American Medical Association, said it was based “on the false premise that almost all persons over 65 need health care and cannot afford it.”

“This is not a fact,” Dr. Orr said. “The truth is that a majority of our older people are capable of continuing a happy, healthy, and, in many cases, productive life. Of the more than 15 million persons in the nation over 65 years of age, only 15 per cent are on old-age assistance.”

Dr. Orr said neither the Administration's proposal nor the Forand-type Social Security approach is tailored to meet the problems of the undetermined number of older persons who, “although able to finance other costs, find it difficult to withstand the additional burden of the cost of illness.”

Dr. Orr advocated the AMA's positive eight-point program for the health care of the aged as a “sensible, economical” plan that would preserve freedom as well as promote security. If both these objectives are to be realized, Dr. Orr said, health care programs for the aged “must necessarily be limited to support for the needy aged and leave to voluntary, competitive, private enterprise, those activities needed to improve the health care of the rest.”

AMA Program

In brief, the AMA program comprises: 1) improved preventive medical care for the aged; 2) a state-administered program of Federal grants-in-aid to states for liberalization of existing old-age assistance programs

so that the near-needy could be given health care without having to meet the present rigid requirements for indigency; 3) better nursing home facilities for the long-term care of aged persons, especially those over age 75; 4) rapid development of health insurance and prepayment policies to provide long-term nursing home care;

5) Expansion of home nursing care services; 6) elimination of compulsory retirement and a basic change in the attitude that a person who reaches 65 has suddenly become non-productive and senescent; 7) health education to instill a "will to live" in older persons and to make them aware of the need for continuing healthful nutrition; and 8) anti-inflationary curbs to maintain the purchasing power of fixed pension and annuity benefits.

A Republican lawmaker, Sen. Barry Goldwater of Arizona, denounced the Administration's plan as "socialized medicine" and a "dime store new deal." The outspoken conservative predicted its ultimate cost would be "staggering." He said the Administration could have done better by proposing "full deductions for taxes for any amount spent for medical care of anyone" and for full costs of health plans by either an individual or corporation.

In endorsing the Administration's plan, Vice President Nixon charged the Forand-type proposals backed widely by Democrats would "open the door for socialized medicine." He said:

"The Forand bill and similar plans would set up a great state program which inevitably would head in the direction of herding the ill and elderly into institutions whether they desired this or not. Such a state program would threaten the high standards of American medicine."

Sen. Pat McNamara (D., Mich.), Chairman of the Senate Subcommittee on Problems of the Aged, headed a group of 16 Senate Democrats who sponsored legislation that would provide hospitalization and medical care for virtually all the nation's older persons.

The co-sponsors included three avowed candidates for the Democratic nomination for president—Sens. Hubert H. Humphrey (Minn.), John F. Kennedy (Mass.), and Stuart Symington (Mo.).

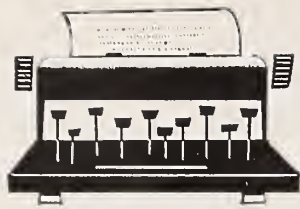
Cost of the McNamara legislation was estimated at \$1,578,000,000 a year. This would be financed by a one quarter per cent increase in the Social Security tax and 370 million dollars from general tax money.

MAG MEMBERS IN WASHINGTON



WASHINGTON LUNCHEON—Candid shot (above) shows part of luncheon group of physicians that met March 31 in Washington, D. C., with Georgia's Congressional Delegation to discuss mutual problems. The luncheon is an annual affair. Standing at the head table is Eustace A. Allen of Atlanta, who presided at the meeting. Brief speeches were presented by each one of the Congressmen and Senators Russell and Talmadge. Several administrative aides of the Con-

gressmen were also present at the lunch. The MAG was represented by 12 physicians, Luther H. Wolff, Columbus; Eustace A. Allen, J. Frank Walker, John T. Mauldin, Atlanta; T. A. Peterson, Savannah; Frank McKemie, Albany; John H. Robinson III, Americus; Virgil Williams, Griffin; John A. Bell, Dublin; Howard Derrick, Lafayette; P. K. Dixon Gainesville, and A. J. Waters, Augusta.



editorials

An Appraisal of Health Care

IN THE APPRAISAL of the health needs of our senior citizens, it has become apparent that there exists confusion as to the terms "health care" and "medical care." The World Health Organization has defined "health" as "a state of complete physical, mental, and a social well-being—not merely of the absence of disease or infirmity." Medical care is one facet of the entire problem, yet in the minds of some, health care and medical care are synonymous. Furthermore, medical care may be measured in a quantitative and objective manner but the measure of quality of medical care and of health care is based usually upon subjective criteria. The use of subjective data makes an evaluation precarious depending, in part, upon what the investigator sees, feels, or interprets to be the true picture.

The Governor's Commission on Aging has endeavored to obtain objective criteria in the search for health resources and unmet needs of our older citizens. The survey conducted has been broad in scope realizing that health depends upon multiple factors. Some of these are:

- (1) Adequate nutrition.
- (2) A well balanced and moderate personal living habit: sufficient rest, appropriate exercise, and personal hygiene.
- (3) Proper attitudes and emotional control: constructive reactions to frustration, the appreciation of social and family values, and the acceptance of one's own limitations.
- (4) A useful and productive role in society: a sense of worth.

- (5) Recreation: in proper balance with work.
- (6) A safe and healthful living environment: to include adequate housing.
- (7) General education and specific health education.

In the preliminary tabulation of the Governor's Commission on Aging the following unmet needs were encountered most frequently:

- (1) The need for more and better nursing homes.
- (2) The need for more screening and diagnostic facilities for older citizens.
- (3) The need for more Home Care Programs.
- (4) The need for more funds for hospitalization and other costs of catastrophic illness.

Suggestions that were outstanding toward satisfying the unmet needs were related largely to education, in its broader sense. It was obvious that reporting sources often were unaware of already existing resources available in their own communities. It was felt that the communities themselves need enlightenment as to:

- (1) Available medical care (general and bedside).
- (2) Available nursing and nursing home care.
- (3) Available economic resources.
- (4) Indoctrinal instruction in general and specific dietary problems (e.g.—diabetic, cardiac, and obesity).
- (5) The need to start teaching early in life just what are the social, economic, and health problems of the aged, and by so doing the development of an educational plan for aging would be required.

(6) The education of individual family units toward their older members was seen as a need and instructions as to how to proceed in accomplishing this must be pointed up.

It is hoped that at the Georgia Conference on Aging to be held in Athens, Georgia at the Center for Continuing Education on June 30-July 1, 1960,

these and many other phases of medical and health care will be brought into focus. In turn, the Governor's Commission on Aging will present recommendations to the Governor for approval and eventual presentation to the coming White House Conference on Aging in January, 1961.

John S. Atwater, M.D.

John Tyler Mauldin Elected Secretary

AT THE *106TH ANNUAL SESSION of the Medical Association of Georgia, held in Columbus, Georgia, May 1-4, John Tyler Mauldin of Atlanta was elected to succeed Christopher J. McLoughlin as secretary of the Association and will serve in this office for the next three years.

A native Atlantan, Dr. Mauldin attended Riverside Military Academy in Gainesville. He received his undergraduate training at Emory University and his M.D. degree from Emory University School of Medicine. His internship was done at Grady Memorial Hospital and he served his residency at Steiner Cancer Clinic, Grady Memorial Hospital, and Lawson VA Hospital.

During World War II, Dr. Mauldin attained the rank of major, serving as Battalion and Regimental Surgeon. Currently he is a colonel in the Georgia Air National Guard, serving as Wing Surgeon.

Dr. Mauldin is a member of the hospital staffs of Emory University Hospital, Grady Memorial Hospital, Crawford W. Long Hospital, and St. Joseph's Infirmary. He is also director of the Sheffield Cancer Clinic at Georgia Baptist Hospital; a member of the Board of Directors and Professional Education Committee of the Georgia Division, American Cancer Society; a member of the MAG committee on Hospital Relations, American College of Surgeons, Southeastern Surgical Congress, and is chairman of the Governor's Commission on Health Care for the Aging.

The new secretary is a member of the Kappa Sigma fraternity, Theta Kappa Psi medical fraternity, is an Atlanta Civitan, and a member of the Druid

Hills Methodist Church.

Dr. and Mrs. Mauldin, the former Ann Scott Harman, have four children and live at 3577 Piedmont Avenue, N.E.



John Tyler Mauldin, Secretary,
Medical Association of Georgia

Congratulations to the new secretary and to the Association for its good fortune in having so able a man to serve in this important office.

Successful Annual Session

THE ANNUAL SESSION held in Columbus last month proved highly successful from many points of view. The excellent physical facilities provided by the Municipal Auditorium and the Navy Building provided easy access to the varied scientific programs. Hotel and motel facilities were adequate in all respects. Especially noteworthy was the smooth and efficient manner in which the individual section meetings were carried out, but even more impressive

was the genuine spirit of hospitality shown by individual members of the host society.

The success of the Columbus meeting bears eloquent testimony to the long hours of planning by the members of the Muscogee Society in cooperation with the headquarters office of the MAG.

Those of us who were privileged to attend this meeting last month will look forward to many more Annual Sessions in Columbus.

1960 CALENDAR OF MEETINGS

State

May 7-10, 1961—Annual Session, Medical Association of Georgia, Atlanta.

Sept. 29-Oct. 1—Georgia TB Association and Georgia Trudeau Society, DeSoto Hotel, Savannah.

Oct. 12-13—Annual Meeting, Georgia Academy of General Practice, Dinkler Plaza, Atlanta.

Regional

Sept. 14-16—Southern Trudeau Society and Southern Tuberculosis Conference, Hotel Francis Marion, Charleston, South Carolina.

Oct. 31-Nov. 3—Southern Medical Association, St. Louis, Missouri.

Dec. 6-8—Southern Surgical Association, Boca Raton Hotel, Boca Raton, Florida.

National

Nov. 28-Dec. 2—American Medical Association, Clinical Meeting, Washington, D. C.

July 20-21—Rocky Mountain Cancer Conference, Hilton Hotel, Denver, Colorado.

July 21-23—Postgraduate Course in Dermatology for GP's, University of Colorado Medical Center, Denver, Colorado.

Aug. 21-26—American Association of Blood Banks, Jack Tar Hotel, San Francisco, California.

Aug. 27-Sept. 1—American Hospital Association, Civic Auditorium, San Francisco, California.

Sept. 1-6—Postgraduate Course in Pediatrics, The Stanley Hotel, Estes Park, Colorado.

Sept. 13-15—National Cancer Conference, American Cancer Society, Inc., and the National Cancer Institute, Minneapolis, Minnesota.

Sept. 24-27—College of American Pathologists, Palmer House, Chicago, Illinois.

Sept. 24-Oct. 2—American Society of Clinical Pathologists, Palmer House, Chicago, Illinois.

Oct. 5-8—American Academy for Cerebral Palsy, Penn-Sheraton Hotel, Pittsburgh, Pennsylvania.

Oct. 9-14—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Illinois.

Oct. 10-12—Congress on Industrial Health, Hotel Charlotte, Charlotte, North Carolina.

Oct. 10-14—American College of Surgeons, Clinical Congress, San Francisco, California.

Oct. 17-20—American Academy of Pediatrics, Palmer House, Chicago, Illinois.

Oct. 18—American Association of Poison Control Centers, Palmer House, Chicago, Illinois.

Oct. 21-25—American Heart Association, Inc., Jefferson Hotel, St. Louis, Missouri.

Oct. 31-Nov. 4—American Public Health Association, San Francisco, California.

Dec. 4-9—Radiological Society of North America, Netherland Hilton Hotel, Cincinnati, Ohio.



IATROGENIC HEART DISEASE

Richard E. Felder, M.D., *Atlanta*

IATROGENIC HEART DISEASE is an emotional disorder in which the patient is more or less crippled by the erroneous conviction that he has heart disease, the conviction having been precipitated or confirmed by a physician. The onset has occurred out of a remark made jokingly by the physician but taken seriously by the patient. More often, however, it has arisen out of errors in diagnosis, particularly misinterpretation of a non-pathological murmur, ECG or x-ray findings from a heart which is displaced or rotated by high diaphragm, pectus excavatum, etc. Perrin Long¹ included in this diagnosis the therapeutic complication of myocardial damage from drugs, as in serum sickness, drug idiosyncrasies (e.g. to the sulfonamides), and digitalis therapy. Warren and Walter² consider the physician himself a therapeutic agent; like other therapeutic agents, this one may have untoward or "toxic" reactions. This author agrees.

Predisposition and Pathogenesis: Vulnerability to the disease increases in proportion to anxiety, especially in certain personality types, specifically hysterical and hypochondriacal. Phobias are one form of hysteria which particularly make fertile ground for its development. Non-neurotic patients are sometimes given mistaken diagnoses of heart disease; the result is not likely to be crippling except for specific limitations on physical activity prescribed by the physician. When this happens to neu-

rotic patients the result may be disastrous, including constant preoccupation with the heart, severe restriction of activity, and even self-imposed complete bed rest.

The neurotic patient is cooperative in the production of the disorder. He comes to the physician with a readiness to find some physical disorder to which to attach his anxiety. As in any symptom of conversion hysteria, the attachment of the anxiety to a bodily organ serves the purpose of binding tension, and perhaps also provides a form of punishment which the patient may feel he needs. Thus the physician does not produce the neurosis, but rather only helps determine the symptomatology by which it will be manifest. The more transference the patient has to the physician the more vulnerable he is.

Prevention: Prevention of iatrogenic heart disease can only be accomplished by recognizing and treating the anxiety which sets the stage, and by not making a diagnosis of heart disease until its presence is proven.

Treatment: Treatment of iatrogenic heart disease in a non-neurotic person is easy. The assurance to him that he does not have heart disease, given by a person with as much authority as the physician who made the diagnostic mistake, is just as effective as the original misdiagnosis. Treatment of the neurotic patient with an iatrogenic heart disease is more difficult. Often it is impossible to persuade the

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

patient that he does not have heart disease. Even if it is possible, and nothing further is done to help with the anxiety, then the anxiety usually shifts to become attached to some other organ. The best approach consists of helping the patient with his anxiety before insisting that he give up his cardiac symptomatology.

Hart,³ in an excellent investigation of iatrogenic heart disease arrived at these conclusions: (1) Frequently the report of the patient as to what the original doctor had said to him was grossly in error. (2) The presence of neurosis in the patient could be demonstrated long before the symptoms shifted to the heart. (3) Reassurance, no matter how emphatic, was no answer in the long run for neurotic patients with iatrogenic heart disease.

Ebaugh⁴ attributes iatrogenicity to failure to recognize emotional factors in illness; inability to treat minor emotional disorders if recognized; and lack of awareness of the role which the physician's feelings, attitudes, and behavior play in the cause

and cure of sickness.

Summary: The responsibility of the physician in the genesis of iatrogenic heart disease does not include the production of a neurosis. It consists of precipitating a specific clinical manifestation of an underlying neurosis. This is still a great responsibility; in industrial compensation cases, for example, the precipitating factor is held responsible for the final effect, no matter how great the predisposition.

The disease is preventable, especially by recognizing and treating emotional illness (and by not treating it as though it were organic). Use of a psychiatrist may be necessary with the candidate for or victim of the disease.

References

1. Long, Perrin H.: The Iatrogenic Aspects of Heart Disease, *New York J. Med.* 55:2637-2641, Sept. 15, 1955.
2. Warren, James V. and Walter, Janet: Symptoms and Diseases Introduced by the Physician, *GP* 9:77-84, June, 1954.
3. Hart, Andrew D.: Iatrogenics and Cardiac Neurosis—A Critique, *JAMA* 156:1133-1138, Nov. 20, 1954.
4. Ebaugh, Franklin G.: Iatrogenicity in Medicine, *J. Mich. State Med. Soc.* 49:79-84, Jan. 1950.

FATAL ACCIDENTS BLAMED ON HUMAN ERROR

MILLIONS OF COLUMN inches of valuable space are contributed by American newspapers every year in the never-ending battle to halt the bloody carnage taking place on our highways. It seems incredible that drivers continue to act as they do behind the wheel of an automobile despite the avalanche of grim facts and warnings.

But it is a matter of record; record that is slightly over 50 years old yet already stands as one of the more sordid indictments against our society.

A recent report by The Travelers Insurance Companies states that since the advent of the automobile, more than 62,000,000 men, women, and children have been killed or injured on our highways. More Americans have died on our highways than in all the wars this country has fought.

The cause of this slaughter screams for attention. More than 85 per cent of all fatal accidents last year was blamed on human error!

More than 85 per cent of the 37,600 deaths occurred because somebody behind the wheel had shrugged off the countless highway safety news stories and editorials newspapers across the country printed during the year. "It can't happen to me," he thought.

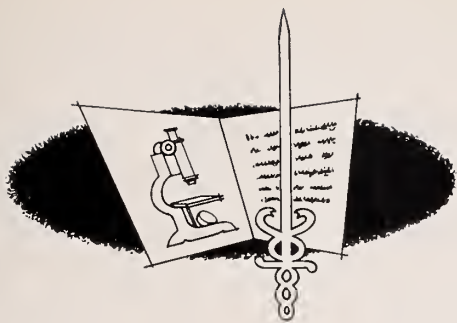
Perhaps he didn't consciously think that. Maybe the

fact that it could happen to him didn't get past his subconscious. Perhaps it never did happen to him. Perhaps he was the survivor in a horrible crash that maimed and killed those he loved most.

Inattention is the overwhelming factor which figures in 85 per cent of our death crashes. A lapse of attention to the road ahead, a heavy foot on the gas pedal, an unnecessary gamble to save a few seconds that cost an eternity—these are the ways in which the human behind the wheel failed. The supreme penalty was the result for those who erred once too often.

Although 3,000,000 copies of the report by The Travelers Insurance Companies describing the sordid record on our highways last year are being distributed in this country, chances are that you will not see one. If you do, however, read it closely. Your error behind the wheel could be included in the statistical columns next year.

It is safe to predict that you as a driver will be exposed to countless news stories in newspapers during the coming months describing what happened because the human behind the wheel made a mistake. Read them carefully. They could help you avoid that same mistake.



cancer page

TEENAGE PROGRAM ON CIGARETTE AND LUNG CANCER

A. H. Letton, M.D., *Atlanta*

IT IS HORRIFYING to comprehend that, according to today's incidence and the mortality rate, more than one million of the children in school today will die of lung cancer before they reach the age of 70. The mortality rate of lung cancer has risen alarmingly in the last 30 years—953 per cent.

Since there are certain reasons to believe that cigarette smoking is in some way intimately involved in lung cancer (10 times as many cigarette smokers die of lung cancer as non-smokers by actual percentage basis), we are compelled to teach our school children these problems. The American Cancer Society's new teenage program of cigarettes and lung cancer will begin with the 1960-61 school year. This program will place facts before these students so that they may draw their own conclusions and then chart the course of their lives.

The program is built around a color-sound film strip which reviews the relationship of cigarette smoking to lung cancer. It explains the effect of chemical compounds in cigarettes on the lungs. Other materials of the program include a teacher's guide with references and suggestions as well as a leaflet for the students reviewing the material in the film strip.

A brief questionnaire will be available in schools to record the smoking levels among students before the program is begun. A re-counting will be made when the program is completed so as to evaluate the

usefulness of the program and its impact on the children.

The American Cancer Society believes that teenagers should know and appreciate the hazards involved in smoking before they establish the habit. It is certainly easier to prevent the habit than to break the habit as we all know when we try to get the "old timers" to stop smoking. Programs of health education are well established in the schools and the American Cancer Society is offering this as an additional help to these courses.

The film strip is also applicable to audiences outside the teenage group. You physicians should see it! The parents and leaders of our churches and organizations concerned with the health and welfare of our youth should see it.

While research continues to find the cause and cure of cancer, we must take full advantage of the knowledge already furnished us. We must remember the relationship of cigarette smoking and lung cancer—we must realize that if fewer people smoked, fewer people would die of cancer of the lung. We hope that everyone of you, our Georgia brother physicians, will encourage—even insist—that your community emphasize this program. Your personal endorsement is of the greatest benefit to the success of this program. Did you ever stop to think that the right word spoken here in favor of this program could result in more lives saved than you could otherwise save in many other ways?

Approved by Professional Education Committee, Georgia Division, ACS.



mental health page

MALINGERING VERSUS NEUROSIS

Tom W. Leland, M.D., *Atlanta*

MALINGERING IS THE DELIBERATE simulation or feigning of an illness. Psychoneurotic symptoms are unconsciously determined and are very real to the patient. Separating either from organic disease may be rather easy. Differentiating the malingerer from the neurotic is more difficult. In this era-of-the-malpractice-suit and with increasing lay publicity of the doctor-patient relationship the physician who deals with these patients often feels caught in a bind. The malingerer and the neurotic both cling tenaciously to their symptoms; however, allowing the patient to "coast along" and keep the symptom produces mutual guilt and mistrust, and the chronically disgruntled patient may become forensically oriented. With the continued popularity of health and accident insurance almost every illness (especially those not responding briskly to treatment) raises some question as to the possibility of "compensationitis" or at least a question as to the role of secondary gain by which is meant the advantage derived from the symptom.

Malingering, though rare, is most consistently seen in compensation cases, prisons, and in the military service. The malingerer, by definition, is consciously lying and knows that he is lying. He voluntarily tries to reproduce symptoms which he either previously had himself or observed in others for some rather obvious gain. This type of person is emotionally ill showing sociopathic (psychopathic) traits or other severe almost life-long character and behavior abnormalities usually quite difficult to treat. The malingerer is sometimes easily identified. He

overdoes his "stunts" when he is aware of being observed. The exaggeration of symptoms is gross, and contrary to the neurotic, the patient resents examination, is defensive, demanding, and frequently has a past history of antisocial behavior.

The neuroses most likely to be mislabeled as malingering are the dissociative reactions (amnesias and fugue states), hypochondriasis, and the colorful conversion hysteria (conversion reaction). These are illnesses resulting from emotional conflict. The conflict is unconscious (though it may appear obvious to the doctor). The patient exhibits gross features of immaturity, emotional lability, impulsiveness, and suggestibility. The physical symptoms are expressed dramatically and in the case of conversion hysteria involve the voluntary musculature (e.g., paralysis), sensations (e.g., stocking-glove anesthesia), or one or more of the special senses (e.g., aphonia, tunnel vision, deafness) without proportionate anxiety (la belle indifference). In general, the conversion symptoms involve functional rather than anatomic units of the body.

Unlike the malingerer, the neurotic is not consciously lying. The patient's body is "lying" to the conscious mind and the knowledge that deception is taking place is repressed and out of the patient's awareness. The reward is temporary freedom from intolerable anxiety; the punishment is the symptom itself (which can be quite crippling despite many secondary gains) and the wasted mental energy involved in maintaining the repressed deception. The underlying emotional conflicts are frequently of a

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

sexual nature and a detailed sexual history usually reveals some real or imagined abnormality.

In both malingering and neurosis there is secondary gain. For the malingerer the gain is obvious to the patient as well as to the doctor. For the neurotic, however, the secondary gain may be denied or obscure to the patient even though it may seem obvious to the doctor. The quantity of secondary gain is variable. Laughlin subdivides secondary gain into conscious secondary gain, and epigain (unconscious motive for symptoms, e.g., basic need to be cared for).

The correct diagnosis does not automatically assure the correct treatment. With the malingerer or "compensationitis" case courteous honesty on the part of the doctor and the recognition of the underlying emotional immaturity may be helpful. The patient may be unwilling to seek out psychiatric help and not infrequently terminates treatment when this

is recommended. The neurotic with conversion hysteria, amnesia, or hypochondriasis may be quite willing (though indecisive) to undergo a psychiatric evaluation. The art of referral to the psychiatrist is frequently "half of the battle" for such a patient.

After the diagnosis has been established a report should be made to the patient with the spouse or important family members present. In this report there should be plenty of opportunity for questions and the patient should be allowed to ventilate some of the repressed conflicts. This is not only good supportive psychotherapy but also helpful in determining how the patient would feel about a more extensive exploring and uncovering type of psychotherapy, should this become necessary.

References

1. Chapman, J. S.: Munchausen's Syndrome, *Journal of the A.M.A.* 165:927-933, 1957.
2. Laughlin, H. P.: *The Neuroses in Clinical Practice*, W. B. Saunders & Co., Philadelphia, 1956.

MEDICAL PREPAYMENT AND OUR SOCIAL PHILOSOPHY

"A CURIOUS PARADOX of some contemporary social philosophy is the idea that man should spend what he earns for his pleasures rather than for what he needs. It is appropriate, so this reasoning goes, that he should buy a television set, a vacation in Florida or an out-board motor boat, because these are cardinal rights. But for something that he really needs, such as his life or his death, or the life of his child, someone else should pay. This may be the Government, his employer, his union, his great-aunt or anyone else who can be cajoled or coerced into paying the price for him. If no one else will pay for it, the doctor should serve him for nothing."

This observation by Dr. C. Marshall Lee, Jr.,* raises a question of crucial importance not only to the medical economy but to the whole pattern of our American society.

For, as Dr. Lee puts it, the attitude he describes "may be acceptable for the child of an indulgent par-

ent, but it is not appropriate for a free man in a free society."

What can the doctor do to counteract this philosophy and to forestall the socialization of medicine which may be its ultimate product?

First, the doctor should learn all he can learn about our voluntary medical prepayment programs. Physicians should recognize that, in Dr. Lee's words, "Far from being the meddlesome 'third party' for which they have an uneasy fear, (the prepayment program) stands with them in the common effort to preserve a cherished concept of freedom."

Secondly, the doctor—and only he—can make these programs operate to the satisfaction of the patient. Only he can see to it that the subscriber gets full value for the premium dollar he has invested in our voluntry medical care program.

Finally, the medical profession's own sponsored Blue Shield Plans offer the American doctor an opportunity not only to strengthen and confirm his patient's confidence in our traditional way of practicing medicine, but also to participate actively in guiding the destiny of our medical prepayment program in the days ahead.

*"The Challenge of Medical-Care Insurance," C. Marshall Lee, Jr., M.D., Assistant Medical Director, John Hancock Mutual Life Insurance Company, *The New England Journal of Medicine*, 262:7, pp. 332-42, Feb. 18, 1960.



physician's bookshelf

BOOKS RECEIVED

Top, Franklin H., M.D., M.P.H., F.A.C.P., **COMMUNICABLE AND INFECTIOUS DISEASES**, The C. V. Mosby Co., St. Louis, Mo., 1960, 812 pp., \$20.00.

Roemer, Milton I., M.D., **SIGERIST ON THE SOCIOLOGY OF MEDICINE**, MD Publications, Inc., New York, N. Y., 1960, 397 pp., \$6.75.

Johnson, Wingate M., M.D., **THE OLDER PATIENT**, Paul B. Hoeber, Inc., New York, N. Y., 1960, 589 pp., \$14.50.

Smith, Homer W., M.D., **FROM FISH TO PHILOSOPHER**, Ciba Pharmaceutical Products, Inc., Summit, N. J., 1959, 304 pp.

Wolstenholme, G. E. W., O.B.E., M.A., M.B., M.R.C.P., and O'Connor, Cecilia M., B.Sc., **VIRUS VIRULENCE AND PATHOGENICITY**, CIBA FOUNDATION STUDY GROUP NO. 4, Little, Brown and Co., Boston, Mass., 1960, 114 pp.

Bakwin, Harry, M.D. and Bakwin, Ruth Morris, M.D., **CLINICAL MANAGEMENT OF BEHAVIOR DISORDERS IN CHILDREN**, W. B. Saunders Co., Philadelphia, Pa., 1960, 597 pp.

Delario, A. J., M.D., **BREAST CANCER**, The Macmillan Co., New York, N. Y., 1959, 208 pp., \$7.00.

Hunter, George W., III, Ph.D., Col. U.S.A. (Ret.); Frye, William W., Ph.D., M.D., Sc.D. (Hon.) and Swartzwelder, J. Clyde, Ph.D., **A MANUAL OF TROPICAL MEDICINE**, W. B. Saunders Co., Philadelphia, Pa., 1960, 892 pp.

Leigh, M. Digby, M.D. and Belton, M. Kathleen, M.D., **PEDIATRIC ANESTHESIOLOGY**, The Macmillan Co., New York, N. Y., 1960, 461 pp., \$12.00.

Hall, Robert E., M.D., **NINE MONTHS' READING**, Doubleday & Co., Inc., Garden City, N. Y., 1960, 191 pp., \$2.95.

REVIEWS

Roth, Arthur, M.D., **THE TEEN-AGE YEARS**, Doubleday & Co., Garden City, N. Y., 1960, 288 pp., \$3.95.

A 288-PAGE, indexed medical guide for young people and their parents. This book is interestingly written and covers a field of medicine that is deserving of more attention than doctors have devoted to it in the past.

Dr. Roth arranged the contents of his book to include brief, understandable descriptions of the various disorders that this age group would encounter and gives common sense advice concerning each one. In addition, he brings out the many natural changes which occur in teen age people and offers reassuring explanations for them. The physician who has occasion to see this age patient would benefit by familiarizing himself with this book.

Clarence W. Mills, M.D.

Modell, Walter, M.D., **DRUGS OF CHOICE 1960-1961**, The C. V. Mosby Co., St. Louis, Mo., 1960, 958 pp., \$13.50.

THIS BOOK WAS so interesting to read that I could hardly put it down. On every page one finds the answers to problems that come up every day in medical practice. There are essays by forty-seven contributors. Although most of the contributors are professors of medicine, there are contributions from professors of pharmacology, neurology, psychiatry, neurosurgery, anesthesiology, obstetrics, gynecology, pediatrics, preventive medicine, ophthalmology, surgery, urology, laryngology, and dermatology.

Drugs that have been in use for many years are thoroughly discussed. In addition, there are excellent discussions of newer preparations which are useful. There is also a good section on fluids and electrolytes. Diuretics are well discussed. There is an excellent section on antibacterial drugs.

The science of pharmacology and the art of therapeutics have changed so much in the past ten years that any doctor other than a recent graduate would find this book very useful. Reading the book will not only be an enjoyable experience; it will also make the reader a better doctor.

Arthur M. Knight, M.D.

Kobler, John, **THE RELUCTANT SURGEON**, Doubleday & Co., Garden City, N. Y., 1960, 359 pp., \$4.95.

THIS BIOGRAPHY OF John Hunter is a particularly intriguing work. It has many advantages in that it should be particularly appealing to physicians who are interested in the development of fundamental sciences which so many of us take for granted today. In addition, it has great historical and literary merit. Hunter worked long and hard to establish basic truths on observation

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

of both the normal and the abnormal of countless species, including the human.

His contributions as a teacher were immense and numbered among his outstanding pupils were Edward Jenner, the discoverer of vaccination for smallpox, and John Morgan who established the first medical school (University of Pennsylvania School of Medicine) in the United States.

Hunter literally carried on countless investigations simultaneously and most particularly in the field of comparative anatomy. As one becomes more engrossed in the volume, one is overwhelmed with the amount of study and documentation this individual was able to accomplish. Particularly interesting was the way the author has interwoven the lives of some of Hunter's associates into the story and their impressions and feelings about this man who was sometimes their mentor and at other times a colleague. London, of Hunter's time, was the dwelling place of such people as Johnson, Boswell, the infant Lord Byron, and the painters, Joshua Reynolds and Thomas Gainsborough, as well as Benjamin Franklin. It is most interesting to note that Hunter numbered these people among his friends and all of them were patients of his. Their accounts of Hunter as an individual, as well as a physician, are particularly fascinating.

On the basis of literary merit, to say nothing of its vivid and factual description of Hunter and his works,

this book alone could be recommended to all. It maintains its interest throughout and is a most enjoyable volume.

Pat C. Shea, Jr., M.D.

DeWeese, David D., M.D. and Saunders, William H., M.D., TEXT-BOOK OF OTOLARYNGOLOGY, The C. V. Mosby Co., St. Louis, Mo., 1960, 464 pp., \$8.75.

THE OUTSTANDING FEATURE of this book is its compactness. The authors use concise, direct sentences. No words are wasted. This enables them to cover the subject thoroughly in 464 pages including 354 illustrations. The illustrations are clear and well-placed. The printing is fairly large and the lines are well-spaced, which makes for easy reading. The book is what the authors claim for it. It is a superb book for students and for the busy general practitioner to have in his office library. Any subject can be easily looked up and at the end of each chapter there is a bibliography for more detailed study if desired. The chapter on speech disorders and their correction should be of interest to anyone dealing with children, including parents.

The portions of the book devoted to modern audiology and otology in addition to being interesting to the student and the general practitioner, make very good reading for any of us in this specialty who wish a quick review of the newer concepts in this field.

Taylor S. Burgess, M.D.

POSTGRADUATE STUDY

The Department of Otolaryngology, University of Illinois College of Medicine, will conduct a postgraduate course in Laryngology and Bronchoesophagology October 17-29, 1960, under the direction of Paul H. Holinger, M.D.

Registration will be limited to 15 physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

The Division of Dermatology of the Department of Medicine, University of Colorado School of Medicine, will conduct a postgraduate course in Dermatology for general practitioners, July 21-23, 1960.

This course is acceptable for American Academy of General Practice Category I credit for the number of hours attended.

For additional information write to: Office of Postgraduate Medical Education, University of Colorado

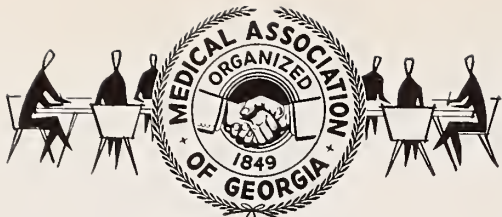
Medical Center, 4200 East Ninth Avenue, Denver 20, Colorado.

The Arthritis and Rheumatism Foundation offers pre-doctoral, post-doctoral, and senior investigatorship awards in the fundamental sciences related to arthritis for work beginning July 1, 1961. Deadline for applications is October 31, 1960.

These awards are intended as fellowships to advance the training of young men and women of promise for an investigative or teaching career. They are not in the nature of a grant-in-aid in support of a research project.

A sum of \$500 will be paid to cover the laboratory expenses of each Postdoctoral Fellow. An equal sum will be paid to either cover the tuition expenses or laboratory expenses of each Predoctoral Fellow. In the case of Senior Investigators, instead of the \$500, an additional 10 per cent of the stipend will go to the institution to be applied to annuity programs, laboratory expenses, travel, etc.

For further information and application forms, address the Medical Director, Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, N. Y.



the association

DEATHS

CHARLES ROSS ADAMS of Atlanta and former Fulton County Commissioner, died suddenly April 20 at Daytona Beach, Fla., at the age of 65.

A native of Texas, Dr. Adams came to Atlanta to attend Emory University and remained to practice medicine.

He was a member of the West End Baptist Church, the Fulton County Medical Society, and the Medical Association of Georgia.

Survivors include his wife; two sons, Dr. Charles Ross Adams, Jr. and Dr. Harold W. Adams, both of Atlanta, and a brother, Dr. A. N. Adams of Daytona Beach, Fla.

WILLIAM TROY BIVINGS, a general practitioner and surgeon in Atlanta since 1899, died at the age of 84 in a private hospital April 11, after a lengthy illness.

He had worked at most of the hospitals in metropolitan Atlanta, and was an honorary staff member of St. Joseph's Infirmary.

Dr. Bivings graduated in 1896 from Emory College, where he was a member of the Sigma Alpha Epsilon fraternity. He received his medical education at Bellevue Medical College on the campus of New York University, interned at Bellevue and the Lying-In hospitals.

He was a member of the St. Mark Methodist Church, the American Medical Association, the Southern Medical Association, the Medical Association of Georgia, Tri-State Medical Association, and the Fulton County Medical Society.

Survivors include his wife and a daughter, Mrs. Clyde L. Crawford of Atlanta.

HUBERT RAWISZER, 75, died at his home in Atlanta May 2. He had practiced medicine in Atlanta for more than 40 years.

Dr. Rawiszer received his medical degree from the old Atlanta Medical College.

He was a life member of the Fulton County Medical Society, a member of the American Medical Association, Medical Association of Georgia, American Academy of General Practice, and the Peachtree Road Methodist Church.

Survivors include his wife and a son, Harry C. Rawiszer, Cleveland, Ohio.

SOCIETIES

The BLUE RIDGE MEDICAL SOCIETY members were guests of C. B. Watkins for a buffet luncheon at his home in Ellijay during their April meeting.

Osler A. Abbott, Emory University chest surgeon, recently spoke at a joint meeting of the Rome Shrine Club, the FLOYD COUNTY MEDICAL SOCIETY, and the members of the Battey Hospital medical staff.

A public forum on rehabilitation of the physically handicapped was conducted recently at the Academy of Medicine in Atlanta and was sponsored by the FULTON COUNTY MEDICAL SOCIETY in cooperation with the Georgia Society for Crippled Children and Adults.

A motion picture entitled "Highlights of the 1959 AMA Convention-Dallas" was shown at the regular meeting of the GEORGIA MEDICAL SOCIETY held May 10, in Savannah.

J. R. Sams, Covington, was elected president of the NEWTON-ROCKDALE MEDICAL SOCIETY during the regular meeting of the organization held in April.

The SIXTH DISTRICT MEDICAL SOCIETY and Auxiliary met recently in Milledgeville, with Dr. Irville H. MacKinnon leading a discussion entitled "A Child Is In Trouble."

Physicians from throughout northwest Georgia and parts of Tennessee met recently at the American Legion Home in Lindale for a medical symposium on cancer, having been co-sponsored by the SEVENTH DISTRICT MEDICAL SOCIETY and the Georgia Division, American Cancer Society.

PERSONALS

First District

GABRIEL d'AMATO of Savannah was recently advised by HARRY B. O'REAR, acting President of the Medical College of Georgia, Augusta, that he had been promoted to Associate Clinical Professor of Psychiatry.

Second District

No news submitted.

Third District

No news submitted.

Fourth District

WILLIAM B. FACKLER, LaGrange, discussed various types of heart diseases at the April meeting of the Greenville PTA.

D. W. PRITCHETT of Barnesville recently attended a postgraduate course in ophthalmology.

The Forand bill was the subject chosen for discussion by GOODWIN TUCK of Covington, who was the guest speaker at the dinner meeting of the Covington Elkadettes recently.

During the April meeting of the Newton County Hospital staff, J. ROSCOE SAMS of Covington was elected Chief of Staff.

DR. and MRS. W. P. KIRKLAND, Manchester, recently attended a medical seminar in Indianapolis, Ind.

Fifth District

WINSTON E. BURDINE, Atlanta, was recently guest speaker for the Cordele Rotary Club.

DAVID A. RUSSELL of Atlanta attended a medical seminar in Indianapolis, Ind., recently.

RIVES CHALMERS, Atlanta, was the guest speaker at the April meeting of the Glenwood School PTA. He also spoke to the North Side Junior Woman's Club in Atlanta during April.

Sixth District

SAM E. PATTON, Macon, recently spoke on "Other Respiratory Diseases" at the annual meeting of the Bibb County Tuberculosis Association.

Seventh District

No news submitted.

Eighth District

W. D. MIXSON of Waycross recently celebrated his 90th birthday.

JOHN A. DUNCAN, Darien, has been advised that his appointment as Medical Advisor to Local Board No. 102, Selective Service System, has been approved.

Ninth District

S. D. BROWN, JR. of Royston was recently selected as a Junior Fellow in the Southeastern Surgical Congress.

THOMAS L. HODGES, Clarkesville, has been elected to serve as president of the North Habersham PTA, beginning in September, 1960.

Tenth District

JOHN A. FAULKNER of Augusta has moved his office to the Augusta Medical Park on Fifteenth St.

JOSEPH D. LEE, Augusta, spoke to the members of the Richmond County Medical Assistants Association held recently at the Georgia Power Auditorium in Augusta.

AUGUSTIN S. CARSWELL, Augusta, recently spoke to the Smyrna Baptist Brotherhood Association.

MAG COUNCIL

THE MEETING OF THE Council of the Medical Association of Georgia was called to order by Council Chairman J. G. McDaniel at 2:35 P.M., March 26, 1960 in the MAG Headquarters Office Building, 938 Peachtree Street, NE, Atlanta, Georgia.

Council members present included: Luther H. Wolff, Columbus, President; Milford B. Hatcher, Macon, President-Elect; Lee Howard, Sr., Savannah, Immediate Past President; Chris J. McLoughlin, Atlanta, Secretary; Thomas W. Goodwin, Augusta, Speaker of the House; Fred H. Simonton, Chickamauga, Vice-Speaker of the House; Charles T. Brown, Guyton, 1st District Councilor; W. G. Elliott, Cuthbert, 3rd District Councilor; Virgil Williams, Griffin, 4th District Councilor; Jack Powell, Newnan, 4th District Vice Councilor; J. G. McDaniel, Atlanta, 5th District Councilor and Chairman of Council; Charles S. Jones, Atlanta, 5th District Vice Councilor; George Alexander, Forsyth, 6th District Councilor; W. H. M. Weaver, Macon, 6th District Vice Councilor; Ralph W. Fowler, Marietta, 7th District Councilor; F. G. Eldridge, Valdosta, 8th District Councilor; Charles R. Andrews, Canton, 9th District Councilor; Paul T. Scoggins, Commerce, 9th District Vice Councilor; Addison Simpson, Jr., Washington, 10th District Councilor; David R. Thomas, Augusta, 10th District Vice Councilor; J. W. Chambers, LaGrange, AMA-MAG Delegate; Eustace A. Allen, AMA-MAG Delegate; and Henry H. Tift, Macon, AMA-MAG Delegate. Also present were: Raymond C. Arp., Atlanta, Treasurer; Edgar Woody, Jr., Atlanta, JMAAG Editor; John Heard, Decatur, Public Service Committee Chairman; J. Frank Walker, Atlanta, Legislative Committee Chairman; Carl C. Aven, Marietta, Inter-Agency Committee on TB; John S. Atwater, Atlanta, Aging Committee Chairman; Lester Forbes, Atlanta, Blood Bank Committee Chairman; and Mr. Frank Shackelford and Mr. John L. Moore, Jr., Atlanta, MAG Attorneys. Members of the MAG Staff present included Mr. Milton D. Krueger, Executive Secretary and Mr. John F. Kiser, Associate Executive Secretary, Atlanta.

Mr. M. D. Krueger read the minutes of the Council meeting, December 12-13, 1959; the Executive Committee of Council meeting of December 13, 1959, January 10, 1960, and February 14, 1960. On motion duly made and seconded these minutes were approved as read.

BLOOD BANK COMMITTEE REPORT—Lester Forbes, Chairman of the MAG Special Committee on Blood Banks, reviewed the present Blood Bank situation in the State of Georgia. He reported on a State Health Department study of Blood Banks in Georgia and described a widespread and uniform blood banking system which had been recommended in January of 1960. He proposed that a Committee on Blood Banks Standardization be formed and that this committee be composed of four organizations, namely: The Medical Association of Georgia, the Georgia State Department of Public Health, the Georgia Hospital Association, and the Red Cross. He stated that the purpose of this committee would be: (1) to organize and extend throughout the state a code of uniform blood banking; and (2) the establishment of a system by which all hospitals might avail themselves of the entire state as a source of blood. He outlined further a program for minimum standards for hospitals—the organization of teaching and referral standards—and a central organization for standards and policies. It was voted (Goodwin-Alexander) to endorse this four organization committee on Blood Banks Standardization and to appoint Walter Sheppard and Lester Forbes as the MAG Representatives on such a committee, and further to assist this organization financially with funds up to \$500.

TB TESTING PROGRAM—Carl C. Aven, Chairman of the Inter-Agency Committee on TB representing the MAG, discussed in detail a tuberculin program of skin testing in the public schools. He stated that case finding is the most important phase of tuberculosis control and skin testing is acknowledged as the most effective means and, further, that this program, as outlined, would be followed up by x-ray and treatment of all positive cases. Dr.

Aven said the schools that conform would receive a certificate of the American School Health Association. On motion (Elliott-Fowler) it was voted to approve this program as outlined by Dr. Aven.

LEGISLATIVE COMMITTEE REPORT—Eustace Allen, Vice Chairman of the MAG Legislative Committee in charge of national legislation, gave a detailed report of pending legislation in Congress. Dr. Allen emphasized the MAG position on Forand-type legislation and described the present status of Forand-type bills now pending before the Congress.

J. Frank Walker, Chairman of the Legislative Committee, discussed state legislation affecting health and medical matters. He briefly discussed mental health activity in the state, the insurance code revision, and other measures introduced into the Georgia General Assembly. Dr. Walker stressed that his committee will recommend a positive legislative program, a public health league association for Georgia, and better means of communication on legislative matters for physicians over the state. By general agreement, the Council highly commended the Legislative Committee for their activity.

HEALTH CARE OF AGING COMMITTEE REPORT—John Atwater, Chairman of the Association Council Committee on Health Care of the Aging, reported on the AMA regional Conference on Aging held in Atlanta recently, a meeting of Southeastern State representatives on care of the aging problems, the forthcoming Governor's Commission on Aging State of Georgia Conference to be held in Athens, Georgia, and the activity of the Georgia Joint Council to Improve the Health Care of the Aging. After describing in detail these various activities, Dr. Atwater asked Council approval of a questionnaire form for the individual physician to be distributed by the members of the Woman's Auxiliary to the MAG on an actual interview basis. Dr. Atwater explained that this form sought certain data to further assess the health care problems of the aging in Georgia. The Council approved such a questionnaire and the enlistment of cooperation from the Woman's Auxiliary to the MAG.

LECTURESHIP COMMITTEE REPORT—George Alexander, Chairman of the Association Lectureship Committee, stated that Council had requested the drafting of a new Bylaw to cover the "ground rules" for Association Annual Session Lectureships. Dr. Alexander then presented the following Bylaw recommendation from his committee as cited below:

"The Lectureship Committee recommends that Chapter 2 of the Bylaws be amended by inserting a new section between the present Section 3 and Section 4; the new section becoming Section 4 and reading as follows:

'Section 4, Lectureships (A) Lectureships for presentation at general meetings may be established by interested donors honoring distinguished deceased members or former members of the Medical Association of Georgia, or honoring someone not a former member or physician who has rendered distinguished service to the Medical Association of Georgia or to Georgia medicine.

'Section 4 (B) Council of the Medical Association of Georgia must approve all lectureships and they must meet the following provisions:

'(1) Medical Association of Georgia Council will control the programming of all approved lectureships.

'(2) That any lectureships, if approved, must be established by setting up a trust fund which shall be in accordance with the pattern of the presently existing lectureship trust fund, or funds.

'(3) The amount of any new lectureship trust fund must be approved by Council.

'(4) A representative of the lectureship trust fund shall be invited to submit suggestions concerning the choice of speakers. Such representatives shall be chosen by Council from three nominees who must be members of the MAG to be submitted by the donor or the trustees of the lectureship fund.'

"The Lectureship Committee further recommends that upon adoption of the above new Section 4 of Chapter 2 of the Bylaws, the present Section 4 shall become Section 5 and the present Section 5 shall become Section 6."

After general discussion (Alexander-Hatcher) it was recom-

mended by Council that the Constitution and Bylaws Committee submit this proposed amendment to the House of Delegates with the Council recommendation for its adoption and this motion was so approved.

Dr. Alexander gave the background and history of the Abner W. Calhoun Memorial Lectureship and further, the Lectureship Committee recommendation of Calhoun A. Witham, Augusta, as the designated representative of the Calhoun Lectureship was approved.

FINANCE COMMITTEE REPORT—Virgil Williams, Chairman of the Finance Committee, presented the monthly budget of the Association and reviewed each item in detail. On motion duly made and seconded, the monthly budget was approved and received for information.

SOCIAL SECURITY DATA—Chris J. McLoughlin, Secretary, presented a communication from the "Committee on Social Security for Physicians, The Physician's Forum of New York" dated March 7, 1960, which requested information about an MAG poll of its membership some two years ago on the issue of social security coverage for physicians. After discussion of this communication, on motion (Goodwin-McLoughlin) it was voted that the Association inform this organization that the poll of its membership was against inclusion of physicians under OASI benefits and, further, that the 1959 MAG House of Delegates unanimously opposed the coverage of physicians by OASI.

Pursuant to the above action, on motion (Wolff-Fowler) it was voted that the MAG Delegates to the American Medical Association be instructed to introduce a resolution to the AMA voicing the MAG House of Delegates opposition to inclusion of physicians under OASI.

ANNUAL SESSION REPORT—Henry Tift, Council Chairman of Annual Session, reported on the 1960 Columbus, Georgia, MAG Annual Session program. On motion (McLoughlin-Hatcher) it was voted to approve this program by Council as required by the MAG Constitution and Bylaws. Dr. Tift then cited two items which were not included in the Annual Session Committee 1960 budget. These items were:

(1) The rental of the Royal Theatre in Columbus for the MAG General Session, Sunday night, May 1 for the Memorial Concert and an Address by the Hon. S. Ernest Vandiver, Governor, State of Georgia. Dr. Tift stated that the rental of the Royal Theatre was \$200.

(2) Dr. Tift then described the "shuttle bus" plans for buses to carry the membership to and from the Municipal Auditorium between hotels and motels and submitted a charge of \$222.28 for this planned rental of buses.

On motion (Tift-Allen) it was voted that the authorization of these two items be given and that the monies be appropriated from the contingent fund.

HEADQUARTERS OFFICE BUILDING COMMITTEE REPORT—Secretary Chris J. McLoughlin, Chairman of the Association Headquarters Office Building Committee, reported on the Shaw-Walker office system procedures presently in progress. He also reported on the expenditures for the new Headquarters Office Building. He also discussed the advisability of a retaining wall between the present MAG property and that property adjacent to it. These matters were given consideration and received for information only.

Dr. McLoughlin then discussed certain necessary equipment and furnishings for the completion of the new MAG Headquarters Office Building. Such items as furniture for the front entrance waiting room, the President's Office, the Council meeting room, and the main meeting hall were given consideration, and on motion (Goodwin-Williams) it was voted that the building should be finished as described by Dr. McLoughlin and, further, that the Executive Committee be empowered to authorize such purchases within the limit of \$6,000.

HEADQUARTERS OFFICE REPORT—Mr. Krueger reported on the status of the personnel in the MAG Headquarters Office. He informed the Council that Mrs. Jeanette Bowman, General Secretary, had resigned and has been replaced by Miss Gale Stanley. He described a proposed meeting in the Headquarters Office for the Executive Secretaries of six county medical societies in Georgia.

This matter had been proposed to the Executive Committee of Council and they recommended approval in principal of this meeting to Council. The expense of such a meeting would be approximately \$100 to cover the travel and luncheon meal for these county society Executive Secretaries. The purpose would be to gain advice as to how better to work with the county societies and also to orient the Executive Secretaries as to the MAG functions. On motion (Wolff-Hatcher) it was voted that such a meeting of Ex-

ecutive Secretaries be approved and the expenses entailed therein to be charged to the contingent fund.

Mr. Krueger stated that the AMA was convening a meeting April 22-23, 1960 in Chicago in preparation for the White House Conference on Aging. He stated that John Atwater and John Mauldin would attend this meeting and he felt it important that he attend in a staff capacity.

Mr. Krueger also sought approval of attendance at the AMA Medical-Legal meeting held in May in Chicago. Pursuant to this meeting, Mr. Krueger stated that he would be in Chicago and the only expense entailed in his attendance at this meeting would be hotel and meals. On motion (Wolff-Hatcher) it was voted to approve Mr. Krueger's attendance at both these meetings with the necessary expenses being charged to office travel.

CULTISTS PRACTICES REPORT—Mr. John Kiser reported on certain situations in the State of Georgia regarding the cultists' practice. This report was received for information.

MEMBERSHIP STATUS—Secretary Chris J. McLoughlin presented communications about Guy Whelchel of Athens, Georgia, concerning his eligibility for life membership (DE 5). This request was reviewed by Council and because of the unusual nature of the request, on motion (Williams-Elliott) it was voted that without setting a precedent, the MAG abide by the local county society action and authorize life membership (DE 5) for Guy Whelchel.

GEORGIA STATE MEDICAL ASSISTANCE QUERY—Mr. M. D. Krueger read a communication of March 4, 1960 from Maude Killorin, President of the Georgia State Association of Medical Assistants. This letter requested the appointment of an Advisory Board from the Medical Association of Georgia and further suggested that Jules Rucker of Augusta and John B. Rabun of Savannah be appointed to serve in such a capacity as they are both very interested in this activity and have members in their offices. On motion (Alexander-Howard) it was voted that such a committee of the Medical Association of Georgia be appointed as an Advisory Board to the Georgia State Association of Medical Assistants by the Executive Committee.

INSURANCE COMMITTEE REPORT—David R. Thomas, Jr., Chairman of the MAG Insurance and Economics Committee, reported on certain matters previously considered by his committee. He discussed group Life of Georgia Insurance Plans for the MAG membership, describing the group term life plan, group health and accident plan, and the group catastrophic hospital-nurse plan.

Dr. Thomas presented a proposal from the Life Insurance Company of Georgia which would become a supplemental agreement and form a part of the present group catastrophic hospital-nurse plan. This proposal was for "widows and dependents of members of the Medical Association of Georgia." The policy was read by Dr. Thomas and he reported that his committee recommended the adoption of such a plan for endorsement by the Medical Association of Georgia. On motion (McLoughlin-Wolff) it was voted that the "Major Hospital and Nursing Benefits for Widows and Their Dependents" as a supplemental agreement attached to and forming a part of group policy GAH 190-C issued by the Life of Georgia Insurance Company to the Medical Association of Georgia, be approved and that the insurance be placed in effect.

Dr. Thomas discussed a proposal for group coverage of the physicians' employees. This was still under study by his committee and at a later date a plan would be presented. He also reported that coverage of the MAG Headquarters Office staff employees was under study.

Dr. Thomas stated that it was the feeling of his committee that retirement plans for the MAG membership shall be deferred at this time due to pending legislation which, if passed by Congress, would alter the type of retirement plan to be considered. Dr. Thomas also discussed the benefits of the Commercial Insurance Company of Newark health and accident plan which was approved by the Association. This data was received for information.

Dr. Thomas reported on his committee's study of the accidental death and dismemberment travel insurance for officers and officials of the Medical Association of Georgia. The committee recommended that consideration of this travel insurance coverage be tabled. After discussion, on motion (Wolff-Howard) it was voted that this travel insurance coverage not be considered at this time.

CORPORATE PRACTICE OF MEDICINE—Lee Howard, Sr. discussed the situation in Savannah and in the 1st District in regard to the corporate practice of medicine by certain hospitals in the fields of radiology, pathology, and anesthesiology. Dr. Howard stated that he would like the Medical Association of Georgia to investigate this problem, preferably in the 1st District; not limiting such an investigation to Savannah. Chairman McDaniel recommended that the society most concerned with this problem is the Georgia Medical Society and that the Council did not have jurisdiction of

the problem until the Georgia Medical Society requested Council's consideration of the problem. It was agreed that Dr. Howard would at some future date have the society request the MAG to consider this problem.

PREPAID HEALTH INSURANCE MEETING—Luther Wolff brought to the attention of the members of Council a National Congress on Prepaid Health Insurance meeting to be held at the Drake Hotel, Chicago, May 13-14, 1960. In a memorandum from the Council on Medical Service of the AMA, the Association was invited to send representation to this meeting. Dr. Wolff recommended that David R. Thomas, Chairman of the Insurance and Economics Committee, attend this meeting and further that, if Dr. Thomas is not able to attend such a meeting, the Executive Committee of Council appoint a MAG representative. This recommendation was approved.

ADVISORY COMMITTEE ON MENTAL INSTITUTIONS REPORT—Luther Wolff, MAG representative on the Advisory Committee on Mental Institutions, gave a resume of the present status of this committee and their activity. Dr. Wolff was commended for his interest and faithful attendance at the meetings of the Advisory Committee and this report was received for information.

FULTON COUNTY MEMENTO—J. G. McDaniel reported that a memento for Fulton County Medical Society, in appreciation of the many years the society provided Headquarters Office space for the Association, had been purchased and would be presented by President Luther H. Wolff at the April 7, 1960 meeting of the Society.

CERTIFICATES OF APPRECIATION—Chairman of Council J. G. McDaniel requested Council members to consider the awarding of MAG certificates of Appreciation to those persons who served the Association in an outstanding manner during the past year. Dr. McDaniel stated that these Certificates of Appreciation are presented at the MAG Annual Session and the recipients are nominated by Council. On motion duly made and seconded, it was voted to award Certificates of Appreciation as follows:

- (1) Luther H. Wolff, Columbus—President of the Medical Association of Georgia.
- (2) Mrs. Remer Y. Clark, Marietta—President of the Auxiliary to the Medical Association of Georgia.
- (3) W. Bruce Schaefer, Toccoa—Chairman of the Milledgeville Study Committee and MAG Councilor.
- (4) Chas. H. Richardson, Sr., Macon—MAG Delegate to AMA.
- (5) J. T. Holt, Baxley—For Civic Service.
- (6) Mr. John D. Arndt, Atlanta—Medicare Administrator.
- (7) H. C. Derrick, Jr., Lafayette—Chairman of the Weekly Health Column Committee.

UNFINISHED BUSINESS—Chairman of Council J. G. McDaniel, called for unfinished business as follows:

- (1) It was suggested that an additional paragraph be recommended to the Chairman of the Committee on Constitution and Bylaws for consideration to enable present pending changes in the Constitution and Bylaws to be clarified. Such paragraph would be added to Chapter 5, Section 2, Nominations to read as follows:

"Nominations from those county medical societies having 100 or more active members which are entitled to elect one councilor and one vice councilor directly representing that society shall be forwarded in like manner as a district society for election by ballot by the members of the Association during the Annual Session."

- (2) On motion duly made and seconded, the Camden-Charlton County Medical Society was hereby given Council approval for Charter as a component county Medical society of the Medical Association of Georgia.

NEW BUSINESS—Chairman J. G. McDaniel called for any new business and it was received as follows:

- (1) A communication from the Director, Dr. Wm. C. Thomas, Jr. of the College of Medicine, Division of Postgraduate Education at the J. Hillis Miller Health Foundation, University of Florida, Gainesville, was read. This communication requested cooperation of the Association in addressing envelopes to all members of the MAG to inform them of the University of Florida College of Medicine-Florida Medical Association sponsorship of a medical cruise to the Caribbean at which time the faculty would conduct a seminar consisting of an intensive program aimed primarily to meet the needs of physicians in general practice. It was voted that the Association cooperate as requested and address such envelopes at no charge.

- (2) AMA Delegate Eustace A. Allen announced the annual meeting of the American Medical Association to be held in Miami, June 13-17, 1960.

the association CONTINUED

(3) President Wolff presented the name of Governor S. Ernest Vandiver as a nominee for the MAG Hardman Award. The Council of the Medical Association of Georgia then nominated Governor S. Ernest Vandiver for the MAG Hardman Award. A Committee was appointed to receive Hardman Award nominations with Luther Wolff, Chairman, and Milford Hatcher and Thomas W. Goodwin as members of the Committee.

(4) On the invitation of President Luther Wolff, the Council voted to meet for their next meeting on April 30, 1960 at 2:00 P.M. in Columbus, Georgia.

(5) On motion, a rising vote of thanks for most cordial hospitality during this Council meeting was given to Dr. and Mrs. J. G. McDaniel, Dr. and Mrs. Charles S. Jones, and Addison Simpson, Jr. The Association Secretary was asked to write a letter expressing the Council's sentiment and appreciation for this hospitality.

There being no further business, Chairman McDaniel adjourned the meeting at 11:35 A.M.

EXECUTIVE COMMITTEE OF COUNCIL

THE APRIL MEETING of the Executive Committee of Council was called to order at 10:00 A.M., Sunday, April 10, 1960 in the MAG Headquarters Office Building by Chairman Luther Wolff, Columbus.

Present in addition to Dr. Wolff were Milford B. Hatcher, Macon; Chris J. McLoughlin, Atlanta; Virgil Williams, Griffin; and J. G. McDaniel, Atlanta. Also present were Mr. Milton D. Krueger and Mr. John F. Kiser of the Headquarters Office Staff.

REVIEW OF MINUTES—Mr. Krueger reviewed the minutes of the Council meeting of March 26-27, 1960. The minutes of the meeting of the Executive Committee for March 27 were read and approved.

AMENDMENT TO CONSTITUTION AND BYLAWS—Dr. Wolff discussed amending the MAG Constitution to provide that the Annual Meeting shall be held on the first Sunday in May each year. It was duly voted to recommend to the Constitution and Bylaws Committee that this Committee submit an addendum report to the 1960 House of Delegates containing this amendment to the Constitution in Article 7. The Executive Secretary was also instructed to draw up standing rules of Council so that these might be available from year to year.

PARA-MEDICAL RECRUITMENT—Mr. Krueger read the four recommendations of the Woman's Auxiliary Committee on Para-medical Recruitment concerning cooperation with the "Joint Council on Para-Medical Education," publication of articles in the *Journal*; distribution of a letter concerning "Career Day" activities to Presidents and Secretaries of County Medical Societies; and distribution of a film "I Am A Doctor." It was voted that the Executive Committee agreed with these views and the matter be referred to Dr. Hatcher for action during his term of office.

MEDICAL TECHNOLOGISTS REQUEST—Dr. Wolff read a letter from Sister Andrew Josephine, representing the Georgia Society of Medical Technologists. It was voted to recommend that the Georgia Society of Medical Technologists work with the "Joint Council on Para-Medical Education," and Dr. Wolff stated that he would reply to this letter.

UNDERGRADUATE NURSES ASSOCIATION—Dr. Wolff read a letter from the Undergraduate Nurses Association and this matter was referred to the MAG Committee on Legislation for further consideration.

APPOINTMENT TO ADVISORY BOARD TO GEORGIA STATE MEDICAL ASSISTANTS ASSOCIATION—Mr. Krueger read a letter from the Georgia State Association of Medical Assistants and the following appointments were made to the new Advisory Board: Jack Hirsh, Columbus; John B. Rabun, Savannah; and Jules Rucker, Augusta. It was stated that this would be a Related Committee.

ADVISORY COUNCIL TO STATE DEPARTMENT OF PUBLIC HEALTH ON LICENSURE AND INDIGENT CARE—Dr. Wolff read a letter

from John Venable concerning MAG appointments to this new committee which takes the place of the Hospital Advisory Committee and the Hospital Care Council. Following discussion it was voted to nominate W. L. Pomeroy of Waycross; Rafe Banks of Gainesville, and A. B. Conger of Columbus to this Council.

CANCER COMMITTEE—Appointment of new members to the Cancer Committee was discussed and Mr. Krueger was instructed to find out the names of the Directors of Cancer Clinics throughout the state and was instructed to place these names on the Committee with Hoke Wammock of Augusta as Chairman of the Committee, Enoch Callaway of LaGrange as Ex-Officio, and the MAG representative on the Committee to be appointed by Dr. Hatcher.

MAG AWARDS—Awards to be given at the Annual Session were reviewed by members of the Executive Committee. It was voted to recommend to Council that a Certificate of Appreciation be given to Lee Howard, Sr., Savannah, in recognition of long years of service on the Council of MAG. Certain problems concerning the presentation of a Certificate of Appreciation for Luther Wolff, President, were referred to the April 30 Council meeting.

LETTER CONCERNING FORAND BILL—Dr. Wolff presented a letter which had been addressed to him concerning MAG opposition to the Forand Bill. It was voted to authorize a reply to this letter by Dr. Wolff.

PHYSICIAN INCLUSION UNDER SOCIAL SECURITY—Mr. Kiser reported briefly on action by the House Ways and Means Committee to include physicians under Social Security. It was voted to authorize a letter from the President with copies to each Georgia Congressman and Senator voicing MAG opposition to inclusion of physicians under social security.

BUILDING COMMITTEE REPORT—Dr. McLoughlin presented several problems concerning the use of the new Headquarters Office building. He discussed types of chairs which had been suggested for the Council room. It was voted to purchase 25 more folding chairs, similar to the ones in the large meeting room, but possibly of a different color. The use of the building by other than MAG groups was also discussed and it was voted to request the Secretary and the Executive Secretary to recommend ground rules for use of the building to be approved by Council at the April 30 meeting.

GEORGIA COMMITTEE ON CHILDREN AND YOUTH—Dr. Wolff presented a request for an MAG representative on the Georgia Committee for Children and Youth. This matter was referred to Grady Black, Chairman of the MAG Committee on School Child Health, for consideration and action.

SPECIAL COMMITTEES—Consideration of Special Committee appointments was referred to Milford B. Hatcher, President-Elect.

STANDING COMMITTEES—Standing Committees were appointed for 1960-61 by the Executive Committee of Council.

There being no further business the meeting was adjourned at 4:00 P.M.

EXECUTIVE COMMITTEE OF COUNCIL

THE FINAL MEETING of the MAG Executive Committee was held at 4:00 P.M., Saturday, April 30, 1960 in the Ralston Hotel, Columbus, Georgia.

Present were President Luther H. Wolff; Immediate Past President Lee Howard, Sr.; President-Elect Milford B. Hatcher; Secretary Chris J. McLoughlin; Finance Chairman Virgil Williams; and Council Chairman J. G. McDaniel, as well as Mr. John F. Kiser of the MAG staff.

MEDICARE REVIEW BOARD—Dr. McLoughlin presented a letter from John Davidson in which he tendered his resignation from the Medicare Review Board as a representative from Columbus. Dr. Wolff stated that he would discuss this matter with the Muscogee County Medical Society and request a nomination to be presented to Council for appointment.

APPOINTMENTS TO MATERNAL & INFANT WELFARE COMMITTEE—Dr. McLoughlin presented a letter from Eugene Griffin, Chairman of the MAG Committee on Maternal & Infant Welfare, requesting the addition of certain physicians to the membership of the Committee. It was voted to add all of the names requested provided that the physicians are members of the Association.

GEORGIA STATE LEAGUE FOR NURSING REQUEST—Dr. McLoughlin presented a letter requesting the appointment of a physician to the Georgia State League for Nursing to act in an advisory capacity. This letter was referred to the MAG Hospital Relations Committee.

There being no further business the meeting was adjourned.

COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA

THE FINAL MEETING of the 1959-60 Council of the Medical Association of Georgia was called to order at 2:00 P.M., Saturday, April 30, 1960 at the Ralston Hotel, Columbus, Georgia by Chairman J. G. McDaniel, Atlanta.

Present in addition to Dr. McDaniel were the following: Luther H. Wolff, President; Milford B. Hatcher, President-Elect; Lee Howard, Savannah, Immediate Past President; Corbett H. Thigpen, Augusta, 1st Vice President; W. P. Rhyne, Albany, 2nd Vice President; Thomas W. Goodwin, Augusta, Speaker of the House of Delegates; Fred Simonton, Chickamauga, Vice Speaker of the House; Chris J. McLoughlin, Atlanta, Secretary; Henry H. Tift, Macon, AMA Delegate; J. W. Chambers, LaGrange, AMA Delegate. The following Councilors were present: Charles T. Brown, Guyton; George R. Dillinger, Thomasville; W. G. Elliott, Cuthbert; Virgil Williams, Griffin; J. G. McDaniel, Atlanta; George H. Alexander, Forsyth; F. G. Eldridge, Valdosta; C. R. Andrews, Canton; Addison Simpson, Jr., Washington. The following Vice Councilors were present: T. A. Peterson, Savannah; Willis P. Jordan, Columbus; Paul T. Scoggins, Commerce, and David R. Thomas, Augusta.

Also present were John Heard, Chairman of MAG Committee on Public Service; Frank Shackelford and John Moore, MAG General Counsel; Charles Johnson, AMA Field Representative; Edgar Woody, Jr., MAG *Journal* Editor, and Messrs. Krueger and Kiser of the MAG Headquarters Office.

REVIEW OF MINUTES—Mr. Kiser reviewed the minutes of the Council meeting of March 26-27, 1960 and these were approved as read. The Executive Committee of Council minutes of March 27 and April 10 were also read and approved.

Mr. Kiser was instructed to add the name of Mrs. Addison Simpson in the Council minutes of March 27 and with this correction the minutes were approved.

CERTIFICATES OF APPRECIATION—Dr. Wolff presented a suggestion that the President be presented a Certificate of Appreciation after he leaves Council as Immediate Past President and not as retiring President. There being no objection, this was so approved.

SUGGESTED RECOMMENDATIONS FOR HOSPITALIZATION FOR DELIVERY—Dr. McDaniel presented a recommendation from the Maternal & Infant Welfare Committee requesting that a statement of policy concerning hospitalization for delivery be approved by Council and published in the *Journal*. It was voted to approve the recommendations.

MUZAK FOR MAG HEADQUARTERS OFFICE—Dr. McLoughlin presented a proposal for Muzak to be installed in the MAG Headquarters Office at no cost to the Association. This was approved.

GROUND RULES FOR USE OF HEADQUARTERS OFFICE—Dr. McLoughlin presented the following ground rules for the new Headquarters Office which were approved on motion (Wolff-Hatcher):

Ground Rules For Use of MAG Building By Other Organizations and Agencies

Definition of MAG Facilities—The Medical Association of Georgia Headquarters Office Building has the following facilities for use by certain eligible organizations and agencies as follows:

- (1) *President's Office*—for conference style meetings of not more than eight persons.
- (2) *Council Room*—for conference style meetings of from six to not more than 30 persons.
- (3) *Meeting Hall*—for auditorium style meetings of not more than approximately 70 persons.

Eligible Organizations and Agencies—State of Georgia chapters, organizations and agencies directly engaged in medical, paramedical, or medical ancillary activities relating to the practice of medicine in Georgia. Other organizations, not falling within the spirit of the eligibility proviso, seeking use of the MAG Headquarters Office Building will be considered on an individual basis at the discretion of the Executive Committee or Secretary of the MAG.

Scheduling Use of MAG Building Facilities—As the primary

use of the MAG Headquarters Office Building is for those activities of the Association, the MAG retains the right to schedule its own activities with first priority at all times. A calendar of Headquarters Office Building usage shall be kept in the Headquarters Office and will be considered the calendar of "booking" for all building facilities.

Responsibilities of Organizations Using MAG Building Facilities—Any organization approved and scheduled for use of MAG Headquarters Office Building facilities shall bear full responsibility for breakage, soilage, or other damage caused by that organization during their use of these facilities. In using the Meeting Hall, the organization shall also be responsible for janitor services connected with the cleaning of the Meeting Hall immediately after such a meeting has been held.

AMA REGIONAL MEETING IN NOVEMBER—Dr. McLoughlin presented a letter from George W. Cooley, Secretary of the AMA Council on Medical Service, requesting cooperation in holding a meeting on Relative Value Index Studies in November. This would be a regional meeting sponsored by the AMA which would be attended by physicians representing state medical societies in the Southeast. It was voted to invite the AMA to hold this meeting in Atlanta in November as requested.

PHYSICIAN LAWYER LIAISON CODE OF COOPERATION—Dr. Dillinger brought up the matter of the Code of Cooperation between physicians and lawyers which had been approved by the House of Delegates and by the Georgia Bar Association. It was voted to request the MAG Physician-Lawyer Liaison Committee to see that this Code is revised, printed, and sent to all physicians in Georgia and that the Georgia Bar Association be informed of this action.

SAMA—Dr. Thigpen brought up the matter of a report from the student Delegates to the Student American Medical Association. It was voted to invite an SAMA representative to report to the September Council meeting.

LETTER FROM PROVIDENT LIFE INSURANCE COMPANY—Dr. Thomas, Chairman of the MAG Insurance & Economics Committee, read a letter from the Provident Life and Accident Insurance Company relative to the group insurance plan formerly sponsored jointly by the Association and Provident. This letter was received as information.

FLORIDA ANNUAL SESSION—Dr. Howard reported on a recent meeting of the Florida Medical Association which he attended as fraternal delegate.

ALABAMA MEDICAL ASSOCIATION MEETING—Dr. Dillinger reported that he was unable to attend the Alabama meeting but had sent a telegram wishing the Alabama Association a successful meeting.

AMA COMMITTEE ON MEDICAL FACILITIES—Dr. McLoughlin read a letter from the American Medical Association praising the work of David Henry Poer, Atlanta, in connection with his service as a member of the Committee on Medical Facilities. It was voted (Dillinger-Goodwin) to request the Speaker of the House of Delegates to read this letter to the Session of the House to be held on Sunday, May 1 in Columbus.

HEADQUARTERS OFFICE REPORT—Mr. Krueger briefly reported on activities of the staff in the Headquarters and stated again the rules for various MAG Awards.

DRUGGISTS PROBLEM UNDER WORKMEN'S COMPENSATION—Dr. Wolff presented a problem concerning release of information in connection with a workmen's compensation case. It was voted that Dr. Wolff should reply to this problem with the assistance of MAG attorney.

FINANCE COMMITTEE REPORT—Dr. Williams presented the report of the MAG Committee on Finance and this was accepted for information.

RESOLUTION ON SOCIAL SECURITY—Dr. Wolff presented a Resolution opposing physician inclusion under Social Security and this Resolution was approved and recommended for approval by the MAG House of Delegates.

CHARLES JOHNSON—Mr. Charles Johnson of the AMA Field Service Staff was introduced by Dr. McDaniel and made a few remarks in connection with activities of the AMA.

OUTGOING MEMBERS OF COUNCIL—Dr. McDaniel thanked the three members of Council, Lee Howard, Sr., Corbett Thigpen, and W. P. Rhyne who are going off Council for their excellent services during the past year and he wished them well.

SOCIAL PLANS—Dr. Wolff briefed the members of Council on Social activities and plans for Saturday night at the Candlelight Restaurant.

There being no further business the meeting was adjourned.

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ENDOCRINE DIAGNOSTIC TESTS

The recent expansion of our knowledge of endocrine physiology has resulted in an impressive array of new diagnostic tests.

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THE CLINICAL APPLICATION of physiologic principles has given us powerful means of substantiating clinical impressions and detecting subtle deviations from normal. These tests, while helpful, are not sources of unvarying truth. The values obtained in a given study do not always fall into clearly defined high, low and normal ranges. Many nonendocrine diseases result in alterations of endocrine diagnostic tests and many seemingly inconsequential clinical considerations alter the final laboratory report.

Only individuals with special interests will wish to master all considerations of clinical endocrine testing. However, certain tests or procedures would seem more strongly indicated in a given situation and certain considerations would modify the results realized from such testing.

The purpose of this paper is briefly to review some of the endocrine diagnostic tests and their interpretation. No effort has been made to include all endocrinopathies. An emphasis has been placed upon those areas where recent progress in endocrine testing has been most impressive.

Thyroid

In the diagnosis of hypothyroidism the protein bound iodine, the basal metabolic rate and the serum cholesterol are the most useful. Isotope studies, of distinctly limited value in hypothyroidism, head the list of useful laboratory procedures in the study of hyperthyroidism. The protein bound iodine and the basal metabolic rate offer sound support.

The basal metabolic rate (BMR), which measures the rate of utilization of oxygen and compares the

rate of the patient with the rate of normal subjects of comparable age, sex, height, and weight, is subject to many sources of error. Erratic breathing creates a pattern which is impossible to interpret. Anxiety in the patient, perforated ear drums and leaks in the tubing lead to spuriously high values. Dubois¹ has reviewed in detail the accurate estimation of the metabolic rate. Even technically satisfactory tracings in the properly-prepared patient are subject to wide variation. Thus, McConahey and associates² found entirely normal subjects to have BMR values of minus 20 to plus 16 per cent. Addison's disease, severe malnutrition and extreme mental depression may be associated with a low BMR, while acromegaly, pheochromocytoma, congestive heart failure and infections may be associated with an elevated BMR.

A serum cholesterol value in excess of 300 milligrams per cent is consistent with, but not diagnostic of hypothyroidism.³ The elevated cholesterol is very sensitive to thyroid replacement therapy and, when thyroid substance is abruptly withdrawn, the cholesterol value tends to rise to levels even higher than the pre-treatment levels. This has served as the basis for a clinical test for hypothyroidism in the past. Although cholesterol levels are often lower than normal in hyperthyroid patients, this is a variable finding and is undependable as a diagnostic test.

The protein-bound iodine determination (PBI) represents an effort to measure circulating thyroid hormone.⁴ This value will be elevated if the patient has been given inorganic iodides, organic iodides such as the ones used in radiography, desiccated thy-

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roid or if the patient is pregnant. Liver disease and nephrosis may be associated with a low PBI. The serum butanol-extractable iodine (BEI) is a better estimate of hormonal iodine because the presence of inorganic iodides in the blood will not elevate this value.⁵ Most other sources of confusing PBI values confuse the BEI values as well. The normal value for protein-bound iodine is 4-8 micrograms per 100 milliliters of serum and the butanol-extractable iodine is 3.2-6.4 micrograms per cent.

Isotope Tracer Studies

Isotope tracer⁶ studies are usually performed with 15 to 100 microcuries of sodium iodide-131. Since the fetal thyroid accumulates the I-131 after 12 weeks of gestation, most centers refuse to give tracer doses to patients when pregnancy is strongly suspected. Many workers prefer not to study patients under 12 years of age, fearing that the rapidly growing thyroid cells might be more susceptible to radiation injury than the adult cell, even with tracer doses. The avidity with which the thyroid accumulates I-131 is directly proportional to the gland's activity in hormone production. Thus, if at two hours after the administration of a tracer dose of iodine the ratio of counts over the gland to the counts over a distant muscle mass exceeds seven, the thyroid cells are overactive. Geiger counting over the thyroid six hours after the administration of I-131 should account for 7-25 per cent of the administered dose, while 14-45 per cent of the dose should be in the gland at 24 hours. Wide variations are seen from one laboratory to another depending on the efficiency and type of equipment and the body iodide pool (*i.e.*, readily exchangeable iodide) characteristic of a given locale. Normal values must be established locally and referred to in the interpretation of a specific study. Hormone production may be evaluated by calculating the ratio of protein-bound I-131 at 24 hours or by calculating the per centage of the tracer dose which is protein bound at 72 hours. The upper limits of normal for these tests are 35 per cent and 0.3 per cent respectively. Lower limits for these values cannot be delineated clearly.

In instances of very active thyroid function a rapid turnover of the iodine in the gland may lead to a 24-hour I-131 uptake in the normal range. A six-hour uptake in this situation will often be elevated. Tracer studies should be delayed for four weeks after the discontinuation of anti-thyroid drugs or thyroid hormone. Iodide, whether inorganic or organic, will expand the body iodide pool and dilute the administered tracer dose to an unknown degree, thereby lowering the uptake values unpredictably. A

one to two week period is ample for the clearing of inorganic iodide, but organic iodide will continue to confuse the studies for as long as six months. In the patient who has had a bronchogram or myelogram, iodine studies may not lend themselves to interpretation for a matter of years.

In the patient with borderline elevations of iodine uptake one may clarify the problem by using the Werner test.⁷ Here the patient is given 25 micrograms of triiodothyronine three times daily for a week. The radioiodine uptake is repeated by the end of the week. In the normal subject the 24-hour iodine uptake will be depressed to the 20 per cent range, while in the hyperthyroid patient little, if any, depression in the iodine uptake will be observed.

A new technique which is in the stage of clinical trial and which deserves attention is the red blood cell uptake of radioiodine-labeled triiodothyronine.⁸ In this test a carefully-measured amount of I-131 tagged triiodothyronine is added to two milliliters of the patient's blood in a heparinized tube. After two hours incubation at 37°C., the whole blood is counted and then the cells are spun down and washed five times with physiological saline. The radioactivity remaining with the red blood cells is then adjusted to a hypothetical hematocrit of 100 per cent. Cell binding, which is inversely proportional to the number of unfilled positions on the thyroid binding protein in the patient's blood, is normally 10-17 per cent/100 per cent hematocrit. Dicumarol therapy and liver disease may be associated with a high value. Pregnancy, estrogen therapy and antithyroid drug administration may be associated with a low value. Values over 17 per cent are seen in hyperthyroidism, less than 10 per cent in hypothyroidism.

Parathyroid

The normal serum calcium is 9-11 milligrams per cent and the serum phosphorous is 3-4 milligrams per cent. Hyperparathyroidism is associated with a tendency towards elevation of serum calcium and depression of the serum phosphorous. Hypoparathyroidism is associated with a depressed serum calcium and an elevated serum phosphorous. Despite active search for better parameters of parathyroid function, the measurement of these two substances in the blood remain the most dependable observations.

Hypoparathyroidism is characterized by low serum calcium and high serum phosphorous in the presence of a normal skeleton, normal serum alkaline phosphatase, normal blood pH and low urinary calcium and phosphorous excretion. These observations viewed in the clinical setting usually lead to a diagnosis. Rarely pseudohypoparathyroidism may be suspected. The intravenous administration of 200 units

of an active preparation of the parathormone should increase the rate of urinary phosphorous excretion within six hours to five times the control value in the normal, 10 times the control value in hypoparathyroidism, and no more than two times control in pseudohypoparathyroidism.⁹ The same hormone should be given a normal subject to ascertain the potency.

The hypercalcemia or hypophosphatemia of hyperparathyroidism may not be easy to document. Several estimations may be necessary. A low phosphorous diet tends to emphasize the elevated calcium and low phosphorous of the blood. There is little to be gained from the estimation of ultrafiltrable calcium, but the determination of total protein and globulin fraction of the blood will help to rule out dysproteinemias and sarcoidosis while a venous bicarbonate ion content will help to rule out the milk-alkali syndrome. In these latter diseases, the serum phosphorous is usually normal.

The normal patient is capable of maintaining calcium balance after three to five days of a diet containing 150-300 milligrams of calcium daily.¹⁰ Patients with excess parathyroid hormone continue to excrete calcium in excess of intake.

Calcium Tolerance Test

A calcium tolerance test may be given on the fourth day of any constant diet. Fifteen milligrams of calcium (as the gluconate) per kilogram of body weight is given intravenously in one liter of 0.85 per cent sodium chloride over a four-hour period. Blood phosphorous determinations are obtained before the test and at two, four, and 24 hours. Urine phosphorous excretion is measured the day before and the day of the test. In subjects with normal parathyroid function, the serum phosphorous rises of the order of 1-2.8 milligrams per cent and the urinary phosphorous is inconsistently reduced. Unfortunately, these changes may be seen in up to one-third of the patients with hyperparathyroidism. In most patients, however, the blood phosphorous remains rather stable.¹¹

Interest has been renewed recently in the study of phosphate clearances and renal tubular handling of phosphorous.¹² These studies may be done in the office. The patient is allowed to eat no dairy products for three days prior to testing. The morning of the test an accurately-timed four hour urine is collected in the fasting state. A blood phosphorous is drawn at the midpoint of the test. The phosphate clearance is calculated by the classical formula, urine concentration in milligrams per milliliter times the urine flow rate in milliliters per minute divided by the blood concentration in milligrams per milliliter. The

phosphorous clearance in normal human beings should be less than 18 milliliters per minute. Errors in timing and collection of samples are eliminated by the calculation of the tubular reabsorption of phosphorous.¹² In this procedure the urine and serum are analyzed for creatinine and phosphorous. Tubular reabsorption of phosphorous is calculated as follows:

$$\% \text{ TRP} = 1 - \frac{\text{serum creatinine} \times \text{urine phosphorous}}{\text{serum phosphorous} \times \text{urine creatinine}} \times 100$$

The concentration of phosphorous and creatinine should be expressed in milligrams per milliliter. The normal values for tubular reabsorption are 79-93 per cent. Hyperparathyroid patients have a reabsorption of phosphorous less than 79 per cent.

Acute, severe hyperventilation will lower the normal serum phosphorous strikingly coincident with a fall of phosphate clearance to values near one milliliter per minute.¹³ This effect has not been studied widely and is an unknown quantity in patients with hyperparathyroidism, so the practical importance of the observation remains to be demonstrated.

Despite the enthusiastic search for better aids in diagnostic study of hyperparathyroidism, the definitive test is yet to be described. Renal disease, commonly seen in far-advanced hyperparathyroidism, obscures every test for parathyroid excess. In early hyperparathyroidism the serum calcium and phosphorous determinations remain the most useful. The other tests of parathormone function are done in the hope of finding a trend, rather than establishing a diagnosis firmly.

Adrenal Cortex

Several tests may be performed in the office to aid in the diagnosis of hypoadrenalism. Thorn popularized the eosinophile response to adrenocorticotropin (ACTH) as a screening test for Addison's disease.¹⁴ In this test a direct eosinophile count is obtained before and four hours after a standard dose of ACTH. The post-injection value should be 50 per cent or less of the control. The counting errors are too great to perform the test when the control blood eosinophile count is 50 cells per cubic millimeter or less. The eosinophile response to injection of epinephrine is not a measure of adrenal integrity. The eosinophile response to ACTH-induced elaboration of hydrocortisone is extremely sensitive and one occasionally sees partial hypoadrenalism with a normal eosinophile test.

A better screening test is the water loading test.¹⁵ While many factors other than adrenal cortex function influence the excretion of water, one does not usually see a good water diuresis in hypoadrenal

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patients in the usual clinical setting. The patient is fasted after 6 P.M. the day before the test and is allowed no cigarettes or alcohol. A sample of urine representing the 10 P.M. to 7 A.M. urine is collected, following which 20 milliliters of water per kilogram of body weight is given by mouth as rapidly as possible. Thirty minutes after water ingestion, hourly urine samples are collected for four hours. The patient should excrete a volume in one of the hourly samples greater than the overnight volume and the excretion of water in four hours should be 50 per cent or more of the administered load. If a failure to experience a water diuresis is repaired by the injection of 100 milligrams of hydrocortisone succinate, the test is even more suggestive of hypoadrenalism.

Batchelor and Mosher¹⁶ have recently suggested use of the response of the urinary sodium excretion to a standard dose of ACTH. In this test the rates of sodium excretion before and three to four hours after ACTH injection are compared. A normal response is a fall in sodium excretion to a level of about half the control value. Hypoadrenal patients do not exhibit any decrease; indeed the sodium excretion may increase during the period of the test. Validity of this test depends upon normal kidneys and depends absolutely upon the collection of control urines from 7-8 A.M. and treatment urine between 11 A.M. and noon.

In the above tests a standard dose of ACTH is defined as 40 units of ACTH-zinc intramuscularly. Lyophilized ACTH may be given in 25 unit doses in a 4-8 hour intravenous saline infusion. Lyophilized ACTH should not be used intramuscularly in diagnostic work.

Measurement of Hormones

Of prime importance in the assessment of adrenal function is the measurement of 17-ketosteroids and 17-hydroxycorticoids in the urine.¹⁷ In some centers the 17-hydroxycorticoids of plasma may be measured, while the plasma 17-ketosteroids are estimated only in research environments. The normal values for these hormones in the blood and urine vary considerably from laboratory to laboratory, depending on nuances in chemical methodology. The urinary 17-hydroxycorticoids are usually of the order of 4-15 milligrams per 24 hours, and the 17-ketosteroids are 5-15 milligrams per day in males and 4-10 milligrams per day in females. These values should respond briskly to the administration of 25 units of aqueous adrenocorticotropin in an 8-hour drip of 0.85 per cent sodium chloride. The post-injection urinary 17-hydroxycorticoids should be 3-5 times

the control. After a similar infusion of ACTH, the plasma corticoids should be at a level of 35-55 micrograms per cent as compared with a normal control value of 4-24 micrograms per cent.

Perhaps a more sound estimate of the adrenal activity that the measurement of 17-hydroxycorticoids, properly called Porter-Silber chromogens, is the measurement of the 17-ketogenic steroids in a 24-hour urine. This chemical technique allows the measurement of certain steroids of adrenal origin which do not give the Porter-Silber reaction. Normal values for the test would be 10-20 milligrams per day in males and 5-15 milligrams per day in females, again depending largely upon individual laboratory variations.

The levels of adrenal steroids and their metabolites in the urine as measured by the above procedures do not allow the physician to classify the cause of the adrenal excess syndromes. In general it may be said that the patients with carcinoma of the adrenal have the highest urinary steroid values of any group. The level of 17-ketosteroids in congenital adrenal hyperplasia approaches the same high level seen in the patients with adrenal carcinoma, 50 to 100 milligrams per day in adults. In the congenital hyperplasia patients, the 17-hydroxycorticoids are most often low to normal, while in adrenal carcinoma these compounds appear in excessive amounts in the urine.

Detection of Adrenal Tumors

Detection of adrenal tumors pre-operatively has been attempted by the observation of urinary adrenal steroid excretion when additional ACTH is given the patient or when endogenous ACTH production is depressed by the administration of cortisone or other glucocorticoid. In theory, the carcinomas and the adenomas are functioning at a rate independent of ACTH stimulation. Such autonomy is not characteristic of adrenal hyperplasia. One would expect no change in urinary steroid excretion in the autonomous tumors, but one would anticipate the urinary steroids of patients with hyperplastic glands to rise or fall with increasing or decreasing ACTH. This sound reasoning is not always rewarded with consistent results. Only in the case of congenital adrenal hyperplasia can the diagnosis be made without surgical exploration.

In the urine of patients with congenital adrenal hyperplasia one may detect pregnanetriol¹⁸ which is not found in normal subjects. This highly specialized test is offered primarily by mail order laboratories, but is of distinct value. An effort to increase the accuracy of diagnosis of tumors of the adrenal has been made by measuring subtle differences in

chemical configuration (3- α hydroxyl versus 3- β hydroxyl) of the steroids produced by the normal adrenal gland and the steroids produced by tumors.¹⁷ This test is often, but not always, helpful and is not widely available.

The diagnosis of primary aldosteronism is extremely difficult at the present. Although urinary assays for aldosterone may be obtained at some expense, the circumstances under which the urine is collected are of such great importance that urinary aldosterone levels are almost worthless unless collected under rigidly controlled conditions by experienced workers.

Posterior Pituitary

The clinical syndrome of diabetes insipidus often is of sufficient clarity to obviate the need for clinical testing. However, many patients with psychogenic polydipsia will have urine volumes of five or more liters per day and will fail to concentrate after overnight water deprivation. A modification of the Hickey-Hare¹⁹ test is done as follows. After an overnight thirst, a catheter is placed in the bladder and the urine flow rate and specific gravity are recorded. A water diuresis is induced by oral administration of 20 milliliters of tap water per kilogram of body weight. The urine flow rate is recorded during two 15 minute periods. Then an intravenous infusion of 2.5 per cent saline is given so that 0.25 milliliters per kilogram per minute run in over a period of 45 minutes. Urine flow rate is recorded in 15 minute periods during the infusion and for two periods thereafter. If a marked drop in the flow rate is not observed, nicotine is administered intravenously in a dosage of 1-2 milligrams for non-smokers and 3-6 milligrams for smokers. Nicotine is available as the tartrate or the saccharinate. The lower dosages should be given first and followed, if necessary, by the higher dosages. Nausea may accompany administration of the nicotine. If the flow rate during the period of nicotine administration does not fall, the patient is given 0.1 unit of pitressin intravenously to determine whether the renal tubules are capable of concentration. In this test, accurate timing and sample collection are vital. We prefer to avoid the use of the catheter and, therefore, interpret the test by following the osmolality of the urine determined cryoscopically with urine flow rate less accurately timed. If the saline infusion is given faster than the prescribed rate, an osmotic diuresis may ensue with high rates of urine flow despite possible antidiuretic hormone activity.

Anterior Pituitary

Assessment of the anterior pituitary function is

usually based upon the study of the various target organs. Growth hormone, of course, cannot be so studied. We can measure gonadotropins directly in the urine with some degree of success. This involves an animal assay and values are expressed in animal units. Prior to puberty the urine is normally without gonadotropic activity. Adult values are from six to 35 mouse units per day and postmenopausal females excrete 50 or more units per day. High values for urinary gonadotropins are found in other cases of primary gonadal failure also. In anterior pituitary failure, the gonadotropins are usually first to disappear.

In hypopituitarism, the 24 hour radioiodine uptake may be low, normal or just within the range of hypofunction. This, with a low BMR and PBI and perhaps with a normal serum cholesterol concentration, is consistent with the diagnosis of pituitary hypothyroidism. If the PBI and I-131 uptake return to normal after intramuscular administration of three units of thyrotropin each 12 hours for three doses, hypothyroidism may be considered secondary to pituitary failure. Similar studies may be performed with ACTH, demonstrating that the low levels of urinary or plasma steroids respond poorly to one injection of 40 units of ACTH-zinc, but after two or three daily doses, respond in an entirely normal fashion.

A promising clinical test of pituitary ACTH reserve is the use of a drug known by the code name SU-4885 and not yet commercially available.²⁰ This drug blocks certain enzyme reactions involved in the production of hydrocortisone. The normal pituitary increases ACTH elaboration in response to this drug-induced decrease in hydrocortisone. This increased secretion of ACTH is reflected in the rise in urinary 17-hydroxycorticoids other than hydrocortisone. Normally this rise in urinary corticoids will equal 3-5 times the control values. A suggested regimen is to collect a 24 hour urine for corticoids, give 500 milligrams of SU-4885 orally each four hours to a total of six doses, then obtain urinary 17-hydroxycorticoids the day of and the day after drug administration. That the adrenal is capable of response to ACTH may be determined by the administration of 40 units of repository ACTH daily for two days, two days after the administration of the enzyme-blocking agent.

Summary

A review has been presented of certain endocrine diagnostic tests. The possible sources of confusion and some aspects of the physiologic basis of the testing have been mentioned.

The most useful studies in hyperthyroidism are the 24 hour thyroidal uptake of radioiodine, the

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protein bound iodine and the basal metabolic rate. Values in excess of 45 per cent, eight micrograms per cent and plus 15 per cent, respectively, are consistent with the diagnosis of hyperthyroidism. In difficult cases the determination of a two hour ratio of radioactivity in the neck to that in the thigh, a six hour iodine uptake or the response to triiodothyronine 75 micrograms daily for a week are helpful. Values in excess of seven, 25 per cent and less than 50 per cent decrease in 24 hour thyroidal uptake of I-131 are consistent with hyperthyroidism.

In hypothyroidism, the protein-bound iodine and basal metabolic rate are preferred. The PBI is usually below four micrograms per cent and the BMR is usually minus 18-20 per cent in hypothyroidism.

The serum calcium and phosphorous remain the best parameters of parathyroid activity. Hormone excess is associated with a calcium value in excess of 11 milligrams per cent and a phosphorous below three milligrams per cent. In deficiency states the calcium drops below nine milligrams per cent and the phosphorous rises above 4.5 milligrams per cent, classically. Other physiologic tests are difficult to evaluate and not entirely dependable.

In evaluation of a patient for hypoadrenalism, the ability to excrete a water load is the most helpful office procedure. Normal adrenal function is present in the patient who excretes 50 per cent or more of a load of 20 ml./kilogram of body weight, of orally-administered tap water, within four hours. The fall of blood eosinophile to less than 50 per cent of the control value, four hours after the administration of a standard dose of adrenocorticotropin is less dependable, though useful. The urinary 17-ketosteroids and 17-hydroxysteroids are essential in defining adrenal function. These values are usually 5-15 milligrams per day and 4-15 milligrams per day, respectively. In the female the 17-ketosteroids are somewhat lower (normal, 5-10 milligrams per day) than in the male. The urinary steroids should respond briskly to ACTH, with the 17-OH steroids reaching 3-5 times the control value and the 17-ketosteroids doubling. In Cushing's syndrome resulting from adreno-cortical hyperplasia, the rise is from a much higher base to a post-injection 17-hydroxycorticoid level of six or more times the control.

Anterior pituitary failure is best studied by studying the end organs, *i.e.*, thyroid, adrenal and gonads. Pituitary follicle stimulating hormone can be measured directly and is normally between six mouse units and 35 mouse units. Administration of SU-4885 in hypopituitarism is not associated with the rise in urinary 17-hydroxycorticosteroids normally seen.

The posterior pituitary function is best studied by observing the patient's ability to concentrate the urine after the administration of a solute load, nicotine injection and pitressin injection as described in the text.

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THE OBSTRUCTED KIDNEY

A PEDIATRIC PROBLEM

Peter L. Scardino, M.D. and Charles L. Prince, M.D., *Savannah*

CONGENITAL OBSTRUCTION OF the kidney at its pelvic outlet and obstruction at the vesical outlet associated with vesico-ureteral reflux are the two most common types of urinary obstruction encountered in infants and children. Awareness of the frequency of pathology at these two critical points in the urinary system of both the male and female patient should do much to increase the frequency of diagnosis.

Obstruction of the ureteropelvic area probably occurs to some degree once in every 500 births.¹ There are no reliable statistical figures relative to the incidence of bladder neck obstruction associated with vesico-ureteral reflux. However, the latter probably occurs in 10 to 12 per cent of children with urologic complaints.² Since both disease entities are congenital abnormalities, their increase in incidence should parallel the sharp increase in population.

Whether the obstruction is high ureteral next to the kidney pelvis or at the bladder outlet associated with ureteral regurgitation, the signs and symptoms are similar. Since the kidney parenchyma is the target of the obstructive forces, the signs and symptoms are a response of the parenchyma to the obstructive pathology. Recurrent episodes of urinary tract infection, characterized by frequency of urination, dysuria, chills, fever, and flank pain is the usual presenting story.

Diagnosis

The diagnosis of ureteropelvic or uretero-vesical—vesical neck pathology is simple. Intravenous pyelography may show the site of pathology, but failure to visualize the collecting system of the kidney by this media will necessitate cystoscopy and retrograde pyelourography by which the diagnosis can be made. Bladder neck obstruction with or without vesico-ureteral reflux can be best diagnosed by: (1) a check for residual urine, (2) cystoscopy, and (3) voiding and delayed cystograms. The cysto-

This abnormality frequently remains silent until irreversible renal damage has occurred.

gram is obtained by injecting from 30 to 250 cc. by gravity of a 10 per cent methiodal sodium (Skiodan®), or a similar contrast media through a urethral catheter. Twenty or 30 minutes after the catheter has been removed, the child is instructed to void. A voiding cystourethrogram is then made. The child too young to cooperate will produce the same type of x-ray if he is made to cry. One must not be misled by previously reported normal intravenous pyelograms because 60 to 70 per cent of patients with vesico-ureteral reflux will have normal intravenous pyelograms.

Etiology

The etiology of congenital ureteral stenosis or stricture is unknown, but the pathology and histology is simply an abnormal narrowing of the duct comparable to similar narrowings so often observed in the lower urinary, gastrointestinal, pulmonary, and biliary tracts. There may be only mucosal redundancies without adventitial changes or there may be sharply localized deficiencies of the ureteral muscularis. External pressures created by retroperitoneal fascia (Gerota's) or aberrant renal vessels occur almost as frequently as inherent ureteral abnormalities.

Obstruction at the bladder neck or vesical outlet may be a form of congenital urethral stricture as a true obstruction or may be an apparent obstruction associated with certain types of neurological disorders of the bladder, especially in spinal cord injuries or disease. Vesico-ureteral reflux may be associated with any one of these types of bladder neck obstruction or may be secondary to urinary tract in-

OBSTRUCTED KIDNEY / Scardino

fection which has produced fibrosis and fixation of the ureter with loss of elasticity of the intramural portion. Too frequently it is impossible to demonstrate ureteral regurgitation. This may be due to diagnostic difficulties or that some inherent defect exists in the intravesical ureter. However, investigators have reported the relief of ureteral regurgitation by increasing the size of the vesical outlet without other surgical intervention.

Management

Once the diagnosis has been established, every effort should be directed toward correction of the pathological process. The elimination of infection in the presence of obstruction is almost impossible. Pathology at the ureteropelvic juncture should be corrected as soon as general conditions justify regardless of the age of the young patient. The creation of a pelvic flap such as that described by Culp,³ and independently by Scardino and Prince,⁴ has been most successful in replacing the stenotic area of the ureter with a ureteral lumen of adequate caliber.

The infant or child with vesico-ureteral regurgitation should first receive conservative therapy such as correction of neurogenic disorders with either drugs or surgical techniques where feasible, and elimination of residual urine secondary to bladder neck obstruction by either urethral dilatation, multiple voidings, transurethral resection or open modification of the vesical neck. Failure to correct vesico-ureteral reflux by conservative measures will necessitate a direct attack on the intramural ureter. The creation of a submucosal tunnel such as that described by Politano and Leadbetter⁵ with simultaneous enlargement of the vesical outlet by the Y-V Plasty of Young,⁶ or the bladder flap techniques of Hudson and Scardino,⁷ has been successfully reported.

Materials

During the past nine years we have been impressed by the response of the young patient to surgical correction of the obstructed lesion of the ureteropelvic area. In a consecutive series of 60 patients with ureteropelvic juncture obstruction, 25 were under 20 years of age. Most of these 25 young people had experienced recurrent urinary tract infection and many showed unilaterally (two patients ages six months and two years respectively showed bilaterally) impaired renal function which was demonstrated by urologic roentgenographic studies. All of these children have responded well to vertical flap ureteropelvioplasty. Because of unusual circum-

stances, the two-year-old male child was submitted to bilateral vertical flap ureteropelvioplasty at the same operative sitting. The six-month-old female underwent bilateral reconstructive ureteropelvic surgery, but an interim of six weeks was allowed to elapse between the surgical procedures.

A parallel study of children with recurrent urinary tract infection has indicated that the incidence of vesical outlet obstruction with or without vesico-ureteral reflux is at least as high as reported by other investigators or perhaps even greater. Alerted by the reports of the association of recurrent urinary tract infection with uretero-vesical regurgitation, we have carefully performed voiding cystourethrograms on all such children. The incidence of reflux in our small series is somewhat higher than the 14 per cent reported by St. Martin, et al.⁸ At least 20 per cent of our young children who have experienced recurrent bouts of urinary tract infection demonstrate vesico-ureteral reflux. Strange indeed, however, is the preponderance of female children who have recurrent episodes of urinary tract infection. Unlike the reports of other investigators into this problem, the incidence of urinary tract infection in the young patient is in the ratio of 10 to one female over male. The significance of this observation is as yet undetermined.

We have with increasing frequency found it necessary to reconstruct the ureterovesical area. Those children who demonstrate vesico-ureteral regurgitation with or without residual urine are first subjected to the conservative measures previously mentioned. If multiple voidings, antibacterial therapy, and urethral dilatations are ineffective, transurethral resection of the vesical outlet is the next procedure of choice. We have found it necessary to perform suprapubic revision of the bladder neck or reconstruction of the ureterovesical area with increasing frequency. The combination of transurethral resection of the vesical outlet in conjunction with appropriate antibacterial therapy, however, has proved satisfactory in our small series of cases.

Ureteropelvic Juncture Obstruction

Case 1. An eight-year-old white female had complained since the age of three years of recurrent left hip and left lower extremity pain. For one year she had been subjected to a rigid program for the treatment of rheumatic fever. Steroidal therapy produced an excessive weight gain which at the age of eight years necessitated hospitalization. During this hospital stay hematuria was observed and the patient had an intravenous pyelogram. (Figure 1). On December 2, 1952 a vertical flap ureteropelvioplasty was performed (supra vide). The patient's post-operative excretory urogram one year later (Figure

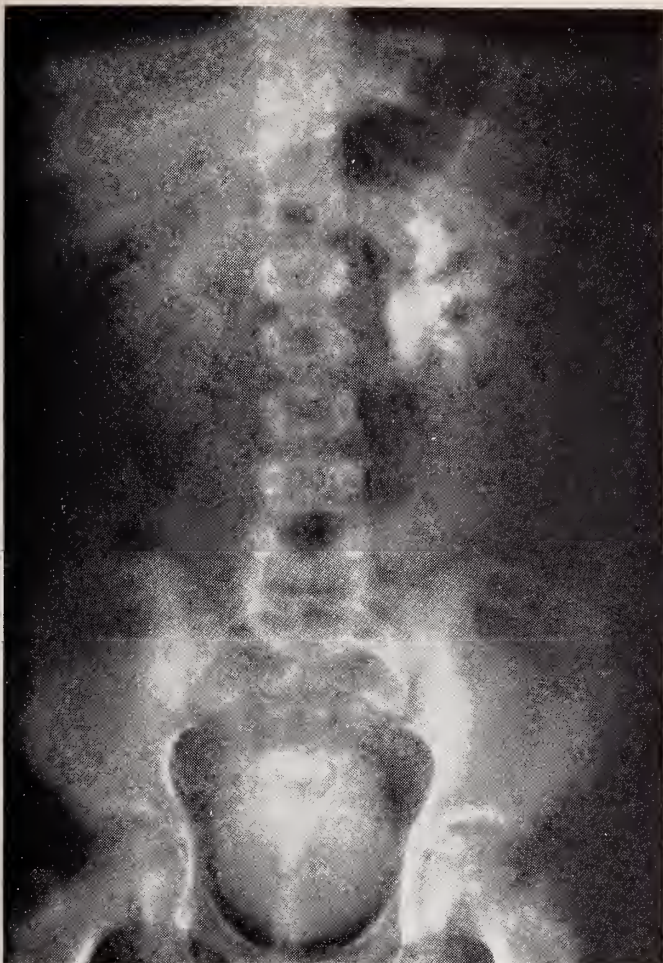


Figure 1: Case 1, pre-operative I.V.P., left hydronephrosis due to ureteropelvic obstruction.



Figure 2: Case 1, post-operative I.V.P. Note: funnel-shaped reconstructed U-P junction, left.

2), and examination six years after surgery revealed the patient to be well and the urine sterile.

Case 2. A 16-year-old white male had complained of intermittent right flank and right lower quadrant pain for several years. At the age of 15 years an appendectomy was performed without relief of the recurrent flank and right lower quadrant pain. Repeated urinalyses were within normal limits. The frequency of the right flank pain increased. An intravenous pyelogram and subsequent right retrograde pyeloureterogram (Figure 3) was made. The grade three hydronephrosis of the right kidney was caused by ureteropelvic junction obstruction. On October 18, 1958 the stenotic area was reconstructed by the vertical flap ureteropelvioplasty technique, (vide supra). The patient's post-operative convalescence was without significant finding. He has remained symptom-free and his urine sterile. Postoperative intravenous pyelograms (Figure 4) three months after surgery shows the right kidney to function well.

Bladder Neck Obstruction with Vesico-Ureteral Regurgitation

Case 3. In 1951 a two-year-old white female was seen for the first time. Urinary incontinence day and night associated with recurrent urinary tract infection

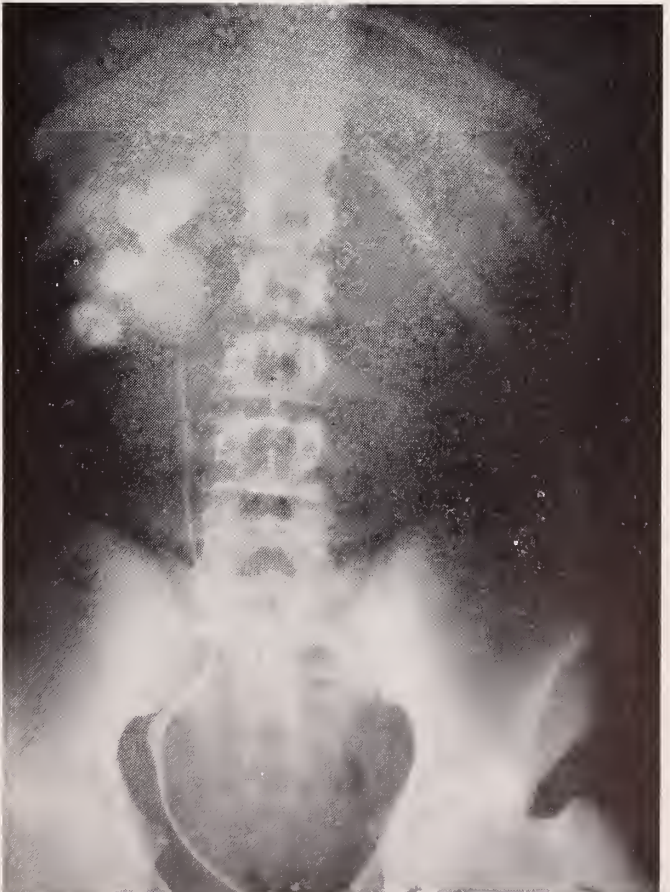


Figure 3: Case 2, pre-operative retrograde pyelogram (I.V.P. was functionless on the right side). Advanced hydronephrosis due to U-P obstruction.

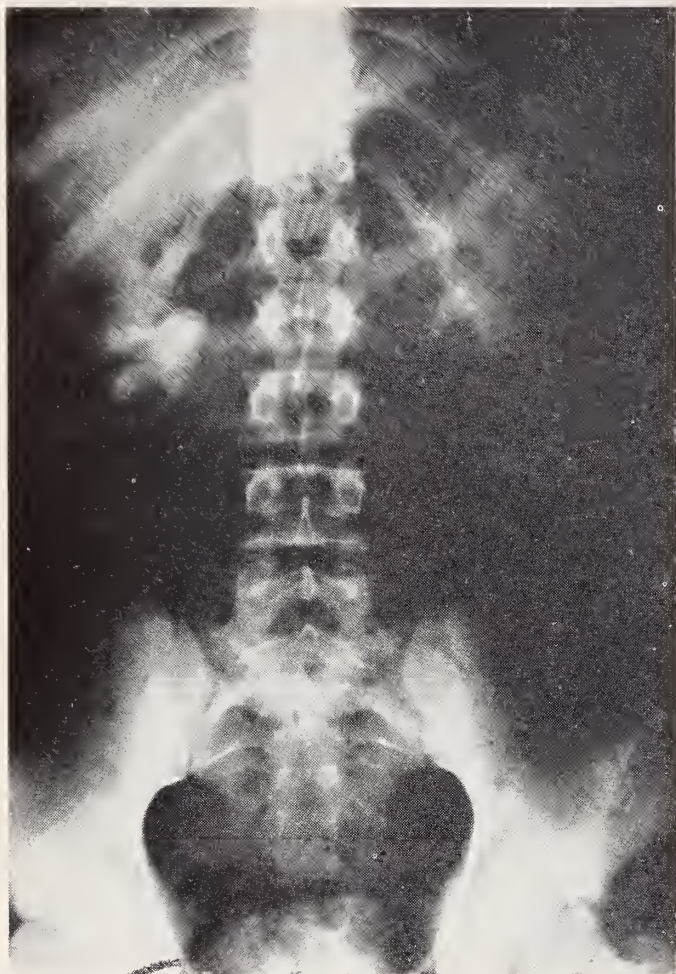


Figure 4: Case 2, post-operative I.V.P. (three months). Note: reduction in hydronephrosis funnel-shaped U-P obstruction.

since birth resistant to conventional antibacterial therapy resulted in complete urological studies. The intravenous pyelogram was thought to be normal. However, subsequent voiding cystourethrograms revealed bilateral vesico-ureteral reflux with obstruction of the bladder neck and residual urine. (Figure 5). In September 1951 transurethral resection of the bladder neck resulted in temporary improvement with complete relief of residual urine. However, recurrent episodes of urinary tract infection prompted a second transurethral resection of the vesical neck in May 1955. In spite of the absence of residual urine and appropriate antibacterial therapy, the patient continued to experience intermittent episodes of pyelonephritis. While she has been symptom-free during the past year, small doses of antibacterial drugs are required to keep the urine sterile.

Case 4. Recurrent attacks of pyelonephritis associated with chills, fever, left flank pain, frequency of urination, and stress incontinence resulted in complete urological investigation of an 8-year-old white female. The initial urological examination, and an intravenous urogram (Figure 6) was normal. A cystogram (Figure 7) revealed bilateral vesico-ureteral regurgitation. On January 22, 1960, trans-

urethral resection of the contracted bladder neck was performed. Residual urine is no longer a factor. The urinary tract infection has not recurred.

Summary and Conclusions

Congenital ureteropelvic juncture obstruction often remains silent until irreversible renal damage has occurred. The pediatrician alerted by an unusual abdominal enlargement, recurrent urinary tract infections, unexplained fever or vague flank pain will make the diagnosis sufficiently early to justify reconstructive surgery. Intravenous pyelogram as well as cystoscopy and retrograde pyelogram can be performed on the young patient regardless of age. Revision of the ureteropelvic abnormality has been accomplished successfully in the majority of cases.

Vesico-ureteral reflux is an abnormal finding regardless of the age group in which it appears. The failure to recognize and treat the condition may lead to irreversible renal damage. Voiding cystograms should be a part of every complete urological investigation in children. Normal intravenous pyelograms mean nothing insofar as the possible existence of vesico-ureteral reflux. Appropriate therapy either conservative or surgical should be instituted immedi-

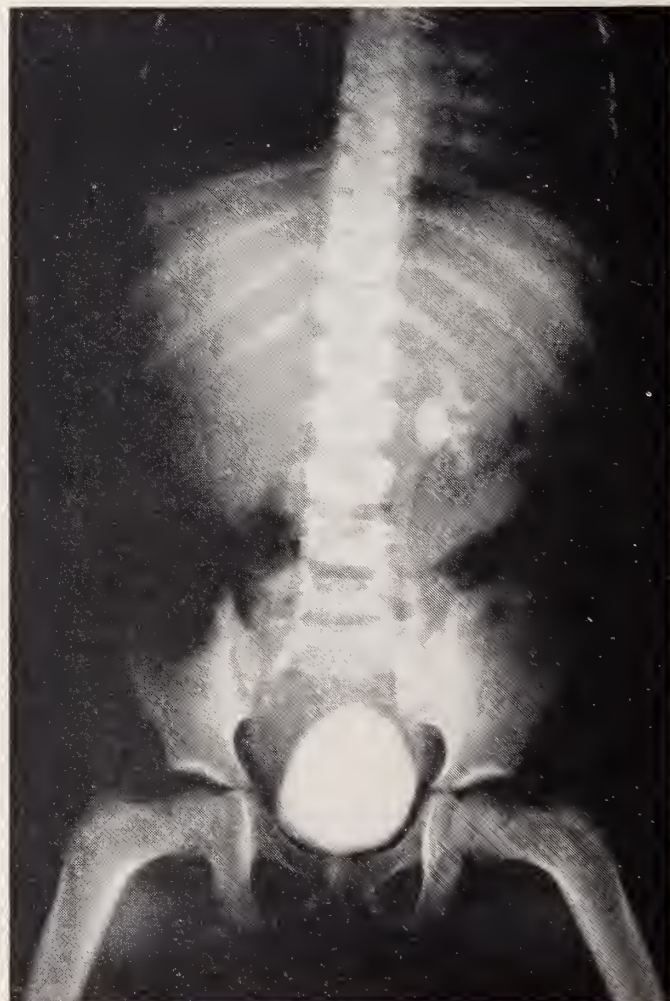


Figure 5: Case 3, voiding cystourethrogram. Note: bilateral vesico-ureteral regurgitation.



Figure 6: Case 4, intravenous pyelogram—normal.



Figure 7: Case 4, voiding cystourethrogram to demonstrate vesicoureteral reflux, bilateral.

ately once the diagnosis has been recognized. If urethral dilatations, multiple voidings and other conservative measures fail, one of various techniques should be performed to enlarge the vesical outlet. If the combination of appropriate antibacterial measures and enlargement of the vesical outlet fails to correct vesico-ureteral reflux and associated infection, a direct attack on the intravesical ureter should be made.

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A REVISED LIST OF films available from the A.M.A. Motion Picture Library has been prepared and copies are now available upon request. This new catalog lists 175 medical films suitable for showing to medical societies, hospital staff meetings, medical students, and other scientific groups. In addition, there are 81 health films of interest to physicians who may be called upon to speak before lay audiences such as service organizations, Parent-Teacher Associations, etc.

The film catalog is completely new in design with such features as eye-ease typography, subject index, alphabetical listing of film titles, order blanks, and a system of color coding so that films for the laity and professional audiences may be quickly identified. Copies may be obtained without charge by addressing your request to the American Medical Association, Department of Medical Motion Pictures and Television, 535 North Dearborn Street, Chicago 10, Illinois.

THE SEVERE, EXHAUSTING, COUGH OF ALLERGIC ETIOLOGY

Carl C. Jones, Jr., M.D. and Clarence L. Laws, M.D., *Atlanta*

The severe and chronic nature of this cough frequently may produce a life threatening problem. The proper treatment consists of determining the etiology of the allergens and relief through avoidance and desensitization.

THE RESPIRATORY TRACT of the human is very subject to allergic reactions and the anatomical location of this altered reactivity determines the symptoms. If the reaction occurs in the nasal passages the symptoms are the typical ones of hay fever; if they occur in the larynx, trachea, and major bronchi, the predominant symptom is one of a chronic hacking non-productive cough, and if the sensitization is in the lower bronchi and bronchioles, the predominant symptom is wheezing. All of these areas may be involved in any one individual, however it is not uncommon to see patients who have selected one of these three areas as their sole or predominant location. Exactly how and why each individual selects his own site for sensitization is unexplained. The sensitivity varies in different parts of the respiratory tract. The mucosa of the larynx and trachea are the most responsive. The smaller bronchi are the least sensitive and the terminal bronchioles and alveoli are unresponsive. The afferent impulses which initiate the cough reflex in the larynx arise from the branches of the superior laryngeal nerve, and in the trachea and bronchi from the afferent fibers of the vagus. We have had occasion to observe a number of patients whose mucosal sensitivity was most marked in the larynx and trachea and who presented a severe exhausting intractable cough which was loud, harsh, dry, brassy, and non-productive, frequently accompanied by a stridor. This is illustrated by the

case histories of four patients who coughed every few seconds or in paroxysms continuing almost 24 hours a day, preventing sleeping and eating, leading to debilitation and exhaustion, requiring hospitalization, oxygen, codeine, and other narcotics for relief. In several cases this was lifesaving from severe exhaustion. None of these people were able to go out in public life or able to perform their usual daily work due to the discomfort and the embarrassment to themselves and others of continuous coughing.

Case Reports

CASE I was Mrs. E. E. O'K., a 49 year old white married housewife with a continuous chronic, dry, non-productive, exhausting cough with hoarseness and stridor which had begun initially two years previously with more frequent and severe recurrences each April and September, although present on a perennial basis. It was usually present evenings and nights without wheezing and none of the usual remedies had been of any help. During her acute episodes the only relief obtained was by hospitalization with use of oxygen, vapor tent, croup tent, and air-conditioning. Physical examination revealed a pale nasal mucosa and a loud, brassy cough with a laryngeal stridor. The lungs were clear and resonant. Examination of the larynx with a laryngoscope revealed large folds of pale edematous redundant membrane with obstruction of the trachea. Routine laboratory studies including chest x-rays and ECG were normal. Skin tests showed positive reactions to house dust, alternaria, and aspergillus. Epinephrine relieved the cough but not the stridor which required Prednisone® 10 mgm. q.i.d. for one week to give complete relief. Avoidance of the allergens and desensitization over three years have given her fairly complete relief of her condition.

CASE II was Mrs. J. H. S., age 40, white married female with a continuous, harsh, dry, non-productive

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cough with a stridor which had begun one year ago. This was perennial and had been present constantly, severely, daily for nine months when first seen in April 1957. Only relief obtained was with ACTH, aminophylline, epinephrine, and hospitalization in an oxygen tent with vapor. At one time she was put on the critical list because of a cough that was so exhausting and debilitating accompanied by marked weight loss. Perennial hay fever had been present since childhood and a family history of asthma was present. Examination revealed an obese lady with a dry, brassy, croupy cough continuous without letup. The nasal mucosa was pale, moist, and edematous and a few wheezes could be heard over both lung fields. Complete laboratory work with x-rays, fluoroscopy, ECG, and blood counts were all normal. Skin tests showed positive reactions to house dust, oak, ragweed pollen, alternaria, and aspergillus. Symptomatic control of her disease was obtained with Prednisone,[®] 10 mgm. q.i.d., epinephrine, aminophylline, and mainly avoidance of her allergens with desensitization over a period of some two years with final relief.

CASE III, Miss M.J.H., age 25, a white single female, had had a similar cough severely for two and one-half years which seemed to arise in the tracheal area, however after prolonged coughing, became deeper and was accompanied by some wheezing. No relief obtained with cough syrups or codeine and was accentuated by talking with occasional pharyngeal and palatal itching. She had reached the point of exhaustion and was unable to work. A bronchoscopy was negative and a diagnosis of habit of coughing was made. Examination revealed a slender poorly nourished debilitated lady with a continuous, harsh, dry, croupy, non-productive cough and a pale nasal mucosa. Laboratory tests including chest x-rays were negative. Skin tests showed positive reactions to dust, alternaria, hickory, pecan, oak, and grass pollens. Epinephrine and Prednisone[®] five mgm. q.i.d. was prescribed. Avoidance and desensitization of allergens over a two year period gave gradual improvement.

CASE IV, Mrs. B.Y.A., age 45, white married female, had a similar cough. This had begun four months previously following a respiratory infection with chronic hoarseness. She had spontaneous improvements and relapses, especially with bad, rainy, wet weather and some daily variation. Some wheezing occurred after severe coughing, especially in the mornings and evenings and after physical exertion. She had a past history suggestive of some hay fever and had arrested pulmonary tuberculosis of 12 years duration. Examination revealed a brassy, tracheal cough with a wheezy forced expiration. The nasal mucosa was pale, moist, and edematous.

Bronchoscopy revealed a pale, moist, edematous tracheo-bronchial mucous membrane. Laboratory tests were all completely negative. Skin tests showed positive reactions to dust, oak, hickory, and pecan. Avoidance and desensitization to her allergens over a period of nine months has gradually given her complete relief. However, during a recent severe unexplained exacerbation her pulmonary tuberculosis was reactivated by the severe coughing and specific therapy for this has begun.

Hints from the History

Certain symptoms should suggest the possibility of an allergic cough. (1) Minor hay fever symptoms of nasal congestion and postnasal drip or history of sinus trouble, which in my opinion is always based on hay fever and cannot occur without an allergic rhinitis or anatomical obstruction; (2) a cough which comes in the mornings and evenings and especially from two to four o'clock in the morning; (3) precipitation by winds, breezes, drafts, weather changes, and temperature changes; (4) seasonal recurrence; (5) response to epinephrine, a beneficial response to steroids not being entirely reliable since this may relieve the inflammatory reaction of a subacute bacterial tracheobronchitis, and (6) precipitation by emotional changes, this being very common among my series of patients.

Symptomatic Therapy

Mild but insufficient benefit may be obtained from the cough mixtures containing antihistamines, dihydrocodeinone, and even codeine along with bronchodilators, both orally and by aerosol. Epinephrine by injection 0.3 cc. every hour or as needed, has been of most benefit, however, is not practical as a long term agent. The severity of this cough usually requires the use of the steroid drugs and our experience has been with Prednisone.[®] Ten mgm. q.i.d. was sufficient to relieve the acute symptoms and was usually employed for the first week, after which time the dosage was decreased as the symptoms allowed. This was continued in most patients as long as three months during which time avoidance and desensitization to the allergens was used to control the disease, however, we have had no hesitation in continuing steroids in whatever dosage or length of time was necessary to provide comfortable, symptomatic relief. There have been no complications of steroid therapy in these patients other than weight gain and retention of salt and water, which disappeared with discontinuance of therapy. The patient with healed tuberculosis was not treated with steroids, although it is felt that one could safely use the steroids in an individual with

SEVERE COUGH / Jones

active tuberculosis for a period of time less than two weeks without fear of accentuating their infection.

Specific Therapy

Etiological therapy is absolutely necessary and this is determined by skin testing and therapy with desensitization. The common association of house dust and mold allergy in this type of patient is emphasized. The delayed reactions to dust, pollens, and molds occur frequently in this type of patient and usually is as important in determining the cause as is the immediate type of reaction. Desensitization requires larger doses of extract with the maintenance dose being two to three times as high as the usual patient with a respiratory allergy. Desensitization should be continued for at least one year. It is my experience that most patients are improved at the end of three months but may require one year

to obtain a definite, worthwhile degree of improvement and may require two years or more for complete relief of symptoms. Desensitization should be continued with maintenance injections every two weeks until the patient has been completely free from symptoms for one full year.

Summary

The mucosa of the larynx and trachea may be the major site of a respiratory allergy and when this occurs a severe, chronic, exhausting, debilitating cough of a non-productive and intractable nature may develop which becomes life threatening. This patient is entitled to adequate symptomatic relief, which usually requires the use of steroids for a prolonged period of time, however, specific therapy consisting of determining the etiology with the help of skin testing followed by avoidance of and desensitization to the allergens is necessary to give permanent relief.

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RECOMMENDATIONS BY MATERNAL AND INFANT WELFARE COMMITTEE REGARDING HOSPITALIZATION FOR DELIVERY

IN SPITE OF the very favorable trend toward hospitalization for delivery, and in spite of the relatively small percentage of total deliveries occurring in the home, there are still more than 11,000 deliveries taking place in the home without a physician in attendance. These deliveries are done by lay midwives who admittedly are inadequately trained and supervised, and for whom there is apparently inadequate legislation.

Maternal death studies in Georgia show that 31 of the 106 maternal mortalities in 1957 and 26 of the 83 in 1958 occurred following home delivery. Most of the maternal deaths occurring following home delivery are preventable deaths and most occur in predictable groups; namely, primipara, grand multipara, patients with complications of pregnancy, and those with poor obstetrical histories.

Most of the case studies show "too little care too late," with the patient moribund before finally being admitted to the hospital.

This Committee feels that one approach is a strong recommendation from the Medical Association of

Georgia that all communities be urged to provide adequate hospitalization, in one way or another, for major obstetrical complications and for those of greatest risk as previously listed. In terms of priorities, when hospital facilities are available, but inadequate to absorb all the lay midwife deliveries, every support should be made at least to meet these needs. This should materially reduce maternal morbidity and mortality. This is one of the real basic problems to be faced today.

Further, the Committee feels that the recommendations, already made, that every woman should have a permit of safety for midwife delivery, signed by a physician, and that such a permit should not be issued without a physical examination, or to a woman with an obstetrical complication, should be re-emphasized, both to physicians in private practice, and to local health departments.

It is felt that recommendations and/or suggestions from the Medical Association can often be helpful in guiding and supporting health department policies and activities.

THE PROBLEM OF TETANUS CONTROL

It is a medical paradox that, with one of the most effective means of prophylaxis available, hundreds of deaths yearly are caused by tetanus.

John Page Wilson, M.D., and A. Hamblin Letton, M.D., *Atlanta*

IN THE OVERALL evaluation of tetanus control, it is quite possible that the treatment is worse than the disease, as the use of antitoxin causes an undetermined number of deaths and certainly more incapacitation than does tetanus itself.

The disease tetanus still carries a mortality rate of 40 to 50 percent and the answer to tetanus control is in its prevention. It is the problem of tetanus prevention with which this presentation is concerned and the problems to be discussed are first, the available means of prevention, secondly the application of these in specific situations, and thirdly, the ultimate approach to the problem.

It is desirable first to review the two types of available prophylaxis: Tetanus antitoxin and tetanus toxoid.

Tetanus antitoxin is a preparation of the antibody globulin derived from horses or cattle immunized against tetanus toxin, having been derived by creating an active response to tetanus in the animal host. When these antibodies are injected into the human it provides a passive type of immunization.

Tetanus toxoid on the other hand is a sterile preparation of the growth products of *Clostridium tetanii* which, by injecting in the patient causes an active production of antibodies. This is active immunization.

The recommended course of active immunization is injection of precipitated or fluid toxoid at one month intervals, followed by a third injection one year later. If the fluid toxoid is used, it is sometimes recommended that an extra injection be given. Reinforcing immunizations are recommended at three to five year intervals and a "booster" shot is given at the time of any injury. For purposes of discussion,

we would like to note that the three initial shots used in immunization will be called "basic immunization," the interval injection at three to five years is a "reinforcing injection" and the injection given at time of injury is called a "booster." These terms define their purpose, although the amount and type of material used is the same in each case.

Antitoxin has only one advantage: it is rapidly effective. It is detectable in the blood stream in a matter of a few minutes following injection, reaches a peak level in two to three days and disappears in ten to 14 days. Tetanus toxoid, on the other hand, cannot give immediate protection unless the patient has been previously actively immunized. It requires at least several weeks before providing significant levels of antibody. Evans¹ has demonstrated this response as shown here in Figure 1. 0.1 unit level is

RESPONSE TO TETANUS TOXOID

First Injection: After 1 month it is barely detectable.

Second Injection: Fairly marked immediate response. Falls to level of 0.1 unit at the end of one year.

Third Injection: (one year) Immediate titer rise to 10. units and at end of 18 months is 0.4 units.

Lower limits of effective level is 0.1 unit.

Figure 1: Response to tetanus toxoid.

considered minimal prophylactic level. It can be seen that after the initial injection, there is only minimal response and quite likely inadequate protection at any interval following initial injection. A second injection one month later produces a marked rise in the titre which fairly quickly subsides to 0.1 unit level, but another injection at one year provides a marked and more sustained rise. This response is subject to recall for a long period thereafter. A "booster" given within ten years of either immunization or a subsequent "reinforcing injection" will

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TETANUS CONTROL / Wilson

provide a protective level in about 90 per cent of patients within four days and almost 100 per cent of the cases within seven days.

The disadvantages of antitoxin on the other hand are numerous. The primary ones are shown in Figure 2.

DISADVANTAGE OF TOXOID

1. Not effective in the unimmunized patient.

DISADVANTAGES OF ANTITOXIN

1. Does not give complete protection.
2. Unit for unit it is less effective than toxoid.
3. 50 - 60% cases of tetanus occur in untreated injuries.
4. Short duration of protection.
5. High incidence of sensitivity.
6. Progressive increase in sensitivity and decrease in effectiveness with repeated doses.

Figure 2: Disadvantages of toxoid and antitoxin.

Effectiveness

There are a number of reports of patients having developed tetanus after a routine dose of 1500 units of tetanus antitoxin. This fact has led to considerable question as to the proper dose of tetanus antitoxin.

By comparison, in World War II in over 2,500,000 persons with wounds treated with tetanus toxoid, only four properly immunized persons developed tetanus. This comparison demonstrates a serious deficiency in the use of antitoxin.

Unit for Unit Less Effective

There has been some evidence that unit for unit the antibody produced by the toxoid is more potent than the horse serum antibody.

Trivial Injuries

Another serious limitation of antitoxin lies in the fact that approximately 50-60 per cent of cases of tetanus occur following accidents, the nature of which has been so trivial that medical care is not sought at the time of the injury. This eliminates the possibility of any passive immunization. In contrast, it has been demonstrated that 88 per cent of persons who have had basic active immunization within five years have a prophylactic titre of 0.1 unit or greater. This provides adequate protection in the majority of cases even without a booster shot. In persons who have had several reinforcing injections at intervals, this percentage undoubtedly is greater. It has been felt in the Atlanta Civil Defense Program that active immunizations are a basic part of the program and one of the few specific and reliable precautions that can be taken in the event of catastrophe and mass casualties. This is one type of Defense that you can take with you at a time when it may be anticipated

that medical materiel will be essentially non-existent.

There is also evidence that titers below 0.1 unit level may be effective. Even when the interval since immunization has been greater than 10 years, in the event that tetanus occurs, the course of the disease is apparently lessened by having had the previous active immunization.

Duration

The short duration of antitoxin has been demonstrated with a maximum duration of 14 days' effectiveness. For this reason repeated administration at intervals may be required in some type of chronic injuries such as burns and wounds that require remanipulation at an interval.

Sensitivities

One of the primary problems in the use of antitoxin is the high percentage of reaction to horse serum. Reactions to serum range from minor type of reactions such as mild erythema to death due to a severe immediate anaphylactic reaction. Responses to the antitoxin may include severe polyarthritis, myocardial infarction and major nerve paralysis. We are familiar with a case recently in which a Guillain-Barre type of reaction developed following tetanus antitoxin administration. The frequency and severity of antitoxin reaction has led some physicians to abandon its use entirely.

In a recent survey (Figure 3) in the Emergency Clinic at Georgia Baptist Hospital, Atlanta, the in-

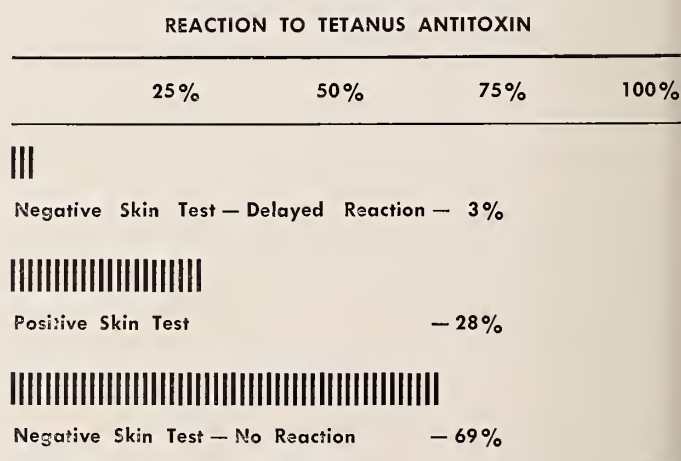


Figure 3: Reaction to tetanus antitoxin.

cidence of positive skin test in routine treatment of out-patients for traumatic cases was 28 per cent in a series of 503 patients skin-tested for tetanus antitoxin. In addition to the 28 per cent incidence of positive skin tests, there was an incidence of delayed reaction in patient with negative skin tests of three per cent. It is of some interest that during this same period of time 2,540 out-patients received tetanus

toxoid as the primary means of treatment. These patients did not have skin testing for tetanus antitoxin.

The patients in this series with positive skin tests were handled one of three ways at the discretion of their individual physicians. (1) They were given antitoxin in divided doses with antihistamines, or (2) were given toxoid $\frac{1}{2}$ cc., or (3) they were given nothing for tetanus prevention. Dividing the dose and giving antihistamines does not give adequate protection against sensitivity reactions and the administration of toxoid in previously unimmunized patients gives no protection at all. In the four-month period during which this survey was made, there was one case of tetanus in a patient who had been treated elsewhere with toxoid at the time of injury despite the fact he had had no previous immunization. This patient died of tetanus 12 hours after admission to the hospital.

It is quite apparent that antitoxin administration carries with it a considerable risk and the physician who is faced with a badly contaminated crushing injury and a markedly positive skin test in an unimmunized patient is truly on the horns of a medical dilemma.

Increasing Sensitivity and Decreasing Effectiveness

As is true in all horse serum preparations, successive doses of antitoxin increases the incidence and severity of sensitivity and also the body response to successive doses of tetanus antitoxin increases the rapidity of its destruction so that its effectiveness becomes progressively less with repeated administration.

In view of the problems involved, we have developed the following general plan of administration of antitoxin and toxoid in cases of trauma:

(a) *Toxoid only*: One-half cc. of precipitated tetanus toxoid only is administered in any patient who has immunization within a five-year period and in relatively clean wounds in which immunization has been within a 10-year period.

(b) *Toxoid and antitoxin*: Tetanus toxoid and tetanus antitoxin 1500 units given in separate sites are administered in the following situations: (1) particularly badly contaminated contused wound or a penetrating wound in which immunization has been over five years, (2) wounds in which immunization has been over 10 years, (3) wounds in which there has been questionable immunization, and (4) patients in whom there has been delay of treatment of the wound for 24 hours and in whom the immunization has been over five years.

(c) *Antitoxin only*: Tetanus antitoxin of 3000 units or more alone has been administered in the

unimmunized patient. The dosage is increased as the time interval between injury and definitive care of the wound increases or as the severity of the injury, particularly as regards contamination and crushing, increases.

The following general considerations are used in this program: (1) tetanus antitoxin and toxoid, if given simultaneously, should always be given at different sites, (2) an initial immunizing toxoid injection may be given if tetanus antitoxin is given in amounts of no greater than 1500 units; if the dosage is larger, however, it is not recommended as the response to toxoid would probably be insufficient under such circumstances, and (3) if the skin test for tetanus antitoxin is positive, evaluation is made on the basis of the severity of the wound, the amount of contamination, the time interval since injury, the location of the wound, and the necessity to close the wound primarily. This, of course, is the ultimate responsibility and decision of the physician handling the case.

It is impossible to discuss tetanus prevention without mentioning a fundamental factor—the *thorough cleansing and debridement of the wound*. Also, in the equivocal situation the wound may be left open as a compromise with questionable tetanus protection.

It should be mentioned that paradoxically having tetanus does *not* immunize against recurrence of the disease.

The evidence that there is no completely satisfactory method of handling the unimmunized patient with a tetanus-prone injury emphasizes the fact that universal active immunization is the *basic answer* to tetanus control.

How can this be accomplished? Fortunately a large part of our population, those who have been in the Armed Services and most pediatric patients, have had basic immunization and it is important that this large segment of our population be encouraged to keep their active immunization current.

Mass Immunization

One approach to the problem of universal active immunization is in organizing a mass immunization program. We would like to offer two examples of this type of program for contrast. Recently in Atlanta, as a part of the Civil Defense program for the Greater Metropolitan Atlanta area, "tetanus clinics" were held at the Academy of Medicine for four afternoons; two days successively at a one month interval. Although there was some support by the major news agencies, we did not receive the support of the newspapers, radio, and television stations that we usually have in similar activities. In a metropolitan area

TETANUS CONTROL / Wilson

which has taken much pride and given much publicity to the fact that it has a population of one million persons, a total of 221 tetanus toxoid shots were given at these four clinics. In Georgia in 1959, there were ten deaths from tetanus for every one due to polio. At the Fulton County Society sponsored shot clinics, there were 50 polio shots given for every tetanus shot.

In contrast, in Savannah mass tetanus immunization programs held on three successive Sunday afternoons during which time all doctors' offices and hospitals were open for toxoid administration at five cents per $\frac{1}{2}$ cc., a total of 22,000 injections were given. This highly rewarding program was organized and effectuated by a committee under the chairmanship of Dr. Richard W. Schley, Jr., and perhaps it is he who should be giving this paper. There have been other successful community-wide immunization programs and this is certainly one approach to the problem. The most effective method of tetanus con-

trol, however, is undoubtedly combining programs of this nature with the effort on the part of every physician to encourage all of his patients to have routine active immunization against tetanus.

It becomes evident that this is a community health problem as well as an individual problem. It is sometimes difficult to interest physicians in community problems as compared with the individual patient's problem. We must realize, however, that community health is the province of organized medicine and the individual physician.

At a time when we are faced with the encroachment upon the practice of medicine by various agencies, it is imperative that we interest ourselves in an attempt to seek solutions to community health problems if we are not to abandon them and refer them to other agencies.

340 Boulevard, N.E.

Reference

1. Evans, D. G.: Persistence of Tetanus Antitoxin in Man Following Active Immunization, *Lancet* 2:316-317, September 11, 1943.



A. M. A. INDUSTRIAL HEALTH CONGRESS TO BE HELD IN NORTH CAROLINA

REPRESENTATIVES OF INDUSTRY, agriculture, medicine, and governmental agencies will gather in Charlotte, N. C., Oct. 10-12, for the 20th Congress on Industrial Health.

To be held at the Hotel Charlotte, the congress is sponsored by the American Medical Association's Council on Occupational Health and is held each year as a means of furthering the development and maintenance of high medical standards in industry and on the farm.

Established in 1938, the council supports safe and healthful working conditions for employees through medical supervision of workers, control of environment, health education, and counseling, according to Dr. B. Dixon Holland, council secretary.

The congress programs are primarily directed toward the general practitioner, whom, it is estimated, handles close to 90 per cent of all the occupational medical practice in the nation.

Among the topics to be discussed during the three-

day conference are occupational health in agriculture, mental and emotional health in industry, problems in dermatitis in farm and industry, and occupational health problems in small employee groups.

Speakers will include Drs. Amos N. Johnson, president, Medical Society of the State of North Carolina; Lemuel C. McGee, Wilmington, Del., Hercules Powder Company; Charles L. Dunham, Washington, D. C., U. S. Atomic Energy Commission; Ralph T. Collins, Rochester, N. Y., Eastman Kodak Company.

Also, V. H. Collisson, New York, vice president, Olin Mathieson Corporation, and Clyde Berry, Ph.D., Iowa City, Institute of Agricultural Medicine, State University of Iowa.

Cooperating sponsors include the Medical Society of North Carolina, North Carolina Governor's Council on Occupation Health, Mecklenburg County Medical Society, and the Greater Charlotte Occupation Health Council.

SYMPOSIUM ON TRAUMA

William M. Byrd, M.D.; David K. McAfee, M.D.;
John S. Jordan, M.D., and John I. Dickinson, M.D., *Atlanta*

Introduction

Dr. William M. Byrd: Initial treatment of the injured is directed toward establishment of an airway and correction of shock. Next, rapid but complete evaluation of the total injury is made. Time is extremely important, if one considers that only four minutes can be allowed for the establishment of an airway; 30 to 45 minutes for the treatment of shock. Speed is also necessary in treating the true neurosurgical emergency of epidural hematoma; thoracic emergency of tension pneumothorax, or orthopedic emergency of vascular insufficiency secondary to unreduced fracture. In addition to this, a multiplicity of semi-emergency situations exists, becoming more pressing as time elapses. Decisions regarding the stability of pulmonary physiology for general anesthesia must be made rapidly.

While methods of treating specific injuries are quite important, the overall care of the patient must be considered before carrying out any therapy of a single component.

In an attempt to give continuity, it is our general policy that patients with two or more organ system injuries be admitted to the general surgical service and that all orders for care shall emanate from that service. Consultation is readily available from the subspecialties. It has been our experience that unless a single physician, who understands the pathophysiology of trauma, has total charge of the patient, good management is difficult, if not impossible, to carry out.

Abdominal Trauma

Dr. David K. McAfee: Injuries to the abdominal viscera result from penetrating as well as blunt trauma. Obviously, every organ is susceptible to injury, and the general surgeon must be aware of

acceptable methods of diagnosis and management of wounds of each organ and system. In penetrating trauma of the abdomen, the diagnosis is generally obvious. It is well to point out, however, that stab wounds are deceptive, and errors will be made if adequate exploration is not carried out in each case. It should also be pointed out here that the plotting of the course of bullet wounds by x-ray and by location of entrance and exit wounds is often unreliable. Blunt trauma presents far more perplexing diagnostic problems. Fortunately, these problems usually resolve themselves with close observation of vital signs, frequent careful physical examinations, serial hematocrit values, and intelligent interpretation of abdominal and chest x-rays.

Certain physical signs are of special value in examining the wounded patient. These include the signs of shock, abdominal tenderness, rebound tenderness, and rigidity. Distention and loss of peristalsis often are reliable signs. Shoulder pain is frequently indicative of blood or intestinal contents free in the peritoneal cavity. The finding of blood in the stomach, rectum or bladder is of obvious significance.

Routine emergency room treatment of the patient with abdominal trauma consists of treatment of shock with plasma expanders and whole blood. Venous cannulation is done, if necessary. Gastric drainage by Levin tube, insertion of indwelling catheter, and tetanus immunization are carried out. Gas gangrene antitoxin is not given unless a positive diagnosis seems likely, but tetanus prophylaxis is used routinely.

Laparotomy should be carried out as soon as possible after the injury with minimal delay for stabilization. If shock persists after rapid administration of 1,000 to 1,500 cc. blood, then further delay in exploration is not warranted on this account.

In most cases a general, intratracheal anesthetic is administered.

Incisions vary with individual surgeons and with

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Presented at the quarterly meeting of the Atlanta Surgical Residents' Society, October 13, 1959, Grady Memorial Hospital, Atlanta, Georgia.

the suspected pathology. A long midline incision is especially applicable to patients in shock with suspected major vascular injuries because of its speed and the fact that it affords adequate access to the abdominal cavity. Transverse incisions are preferred by many because of the decreased incidence of wound disruption postoperatively.

Exploration in Systematic Fashion

Exploration is carried out in a systematic fashion. The liver and spleen are visualized. The anterior surface of the stomach and first portion of the duodenum can also be inspected. The small bowel and its mesentery can quickly be explored by evisceration and then a careful inspection from the ileocecal valve to the ligament of Treitz. The colon must be examined from the cecum to the rectum; this frequently entails mobilization of the hepatic and splenic flexures by dividing their peritoneal attachments. The pancreas is best examined through an incision in the gastrocolic omentum. The posterior peritoneum is not opened unless there is indication of possible injury to one of the retroperitoneal organs. The kidneys and ureters can be adequately examined by medial reflection of the right or left colon. Before opening retroperitoneal hematomas, one must be prepared to deal with immediate profuse hemorrhage.

The liver, spleen, and kidneys are vulnerable both to blunt and penetrating trauma. Any injury to the splenic capsule, parenchyma or its vascular attachments is indication for removal of that organ. Liver injuries are frequently encountered and although bleeding may be severe at first, it frequently has ceased at the time of laparotomy. In such case, inspection and drainage suffices. If hemorrhage continues, it may be controlled by the prudent use of hemostatic agents such as gelfoam, or by suture using blunt needles and heavy catgut sutures. In the past 10 years, there have been 189 patients admitted to this hospital with liver injuries. Roughly the mortality correlates directly with the amount of transfused blood and the number of organs injured. The overall mortality was 16.8 per cent. In an occasional case, hepatic lobectomy is indicated. Principles of liver resection developed in the treatment of malignant disease must be followed; that is, resection along predetermined planes, control of major vessels at the hilus and accurate resection so as to avoid leaving behind an excess of devitalized liver. A left hepatic lobectomy was recently done here successfully for a gunshot wound involving the left hepatic vein. Wounds of the gall bladder generally necessitate

cholecystectomy. Cholecystostomy has occasionally been utilized successfully when the patient's general condition did not warrant cholecystectomy.

Renal injury can frequently be suspected by the nature and location of the injury and confirmed by findings of hematuria or tumor in the region of the kidney. Intravenous and retrograde pyelography are of value in determining extent of injury and presence of extravasation. In the past 10 years there have been 137 cases of renal injury admitted to this hospital. Surgery was carried out in 73 cases; 60 of these were laparotomies for other intraperitoneal injury. Nephrectomy (partial or complete) and drainage usually were performed.

Wounds of the stomach should be debrided and accurately closed in two layers so as to avoid the complications of postoperative hemorrhage.

Duodenal injuries are quite serious due to close proximity of major vascular structures and frequent injury to pancreatic and biliary ducts. The mortality in World War II was 56 per cent; in the Korean War it was 41 per cent. A ten year study of cases admitted to Grady and Jefferson Davis Hospital in Houston, Texas, consists of 50 cases. Forty-four had duodenorrhaphy; the remaining had gastroduodenostomy or duodenojejunostomy. The mortality was 28 per cent.

Injury to the pancreas likewise presents serious problems of management. This is because of difficulties encountered in exposure and in control of hemorrhage. Exposure is best accomplished by incision through the gastrocolic omentum. Hemorrhage can be best controlled by suture ligation. In severe injuries to the body or tail of the pancreas, distal resection occasionally is indicated. Adequate drainage is imperative, and frequent use of sump drains is recommended. Pancreatic injuries are frequently complicated by delayed hemorrhage, breakdown of adjacent suture lines, pancreatic fistulae, and development of pseudocysts.

Wounds of Small Bowel

Wounds of the small bowel are most frequently due to penetrating wounds; not infrequently complete transection or mesenteric lacerations are the result of blunt injury. Small isolated perforations are treated by debridement and closure in one or two layers or by purse string sutures. Wounds of the mesenteric border are treacherous and, in general, require resection due to interference with the vascular supply. Multiple wounds in a short segment require resection. Complications other than those inherent to major abdominal surgery are infrequent.

Injuries of the colon are usually the result of stab or gunshot wounds. The management of this type

injury is universally controverted. Treatment here has consisted of debridement and suture alone in selected instances where contamination was minimal and the extent of the injury was not great. In wounds of greater magnitude, management has been either closure with proximal diverting colostomy or exteriorization of the injured segment as a loop colostomy. The latter is believed to be the safest course to follow in the majority of cases. Wounds of the cecum and ascending colon present special problems because of difficulty in mobilizing this segment of bowel. Frequently this type of wound can be converted to a tube cecostomy with good results.

Wounds of the rectum are treated by proximal diverting colostomy and posterior drainage of the pararectal spaces.

Hematomas in the region of the bladder are frequently indicative of injury to this organ, either by penetration or by tearing associated with pelvic fractures. These wounds are best treated by establishment of through-and-through drainage utilizing suprapubic cystostomy and indwelling urethral catheters. The retropubic space is drained in all cases.

Chest Trauma

Dr. John S. Jordan: Trauma to the chest might be divided into two groups, penetrating and non-penetrating. A review of penetrating chest wounds at Grady Memorial Hospital from 1948 through 1956 showed 769 cases diagnosed as penetrating lung or pleura. All cases required admission to the hospital. Initial findings included shock, dyspnea, pain, and hemothysis. Pneumothorax (134 cases), hemothorax (136 cases), and pneumohemothorax (465 cases) were the most frequent manifestations of thoracic injury.

The plan of management of the cases was based on the treatment of shock, restoration of normal cardio-respiratory physiology, followed by the treatment of any complication or sequelae. Sucking wounds of the chest were immediately sealed with petrolatum gauze and adhesive strapping. One-third of the patients were in shock on admission. Open wounds of the chest or pneumothorax may produce shock that is unresponsive to replacement therapy. When treatment of shock is satisfactorily under way, the penetrating wound is cleansed, debrided, and possibly closed. Preventive measures against tetanus are given at this time. If the condition of the patient permits, x-ray examination of the chest is carried out. While portable chest x-ray does not produce the most diagnostic film, it generally will provide information of value for the immediate treatment. Antibiotic therapy was instituted as part of the emergency treatment in all cases.

Pleural aspiration was widely used to restore normal physiology. Unless a hemothorax showed opacity up to the fourth or fifth interspace anteriorly, no aspirations were done from 12 to 24 hours. The pleural space was aspirated daily until dry or less than 50 cc. of fluid could be obtained. A valuable tool in the case of massive hemothorax was the aspiration of blood into a citrated bottle for autotransfusion.

Insertion of water seal thoracotomy tube drainage was used in 24 per cent of the patients. Indications for its use were tension pneumothorax, open wounds, severe subcutaneous emphysema, and use of general anesthesia. Tubes were not inserted for fluid drainage initially, the fluid being removed by aspiration even if the tube were in place. On the average thoracotomy tubes were removed on the third day. This was done when there was no bubbling in the water seal bottle or there was no further development of pneumothorax with the tube clamped for 12 to 24 hours.

Empyema developed in 3.3 per cent. All of these patients had either thoracotomy tubes (19 cases) or multiple aspirations (six cases). Bronchopleural fistulae developed in 14 patients. Most of these sealed within two weeks with three bottle suction.

The overall mortality rate was 3.8 per cent. (If shock were present on admission, the mortality rate was nine times as great as the absence of shock). Eighty-four major abdominal operations were done with 11 deaths (13 per cent). If no associated injury were present, the mortality rate was 0.9 per cent. If four associated injuries were present, the mortality rate was 66 per cent.

In the group receiving blunt trauma, 216 required hospital admission. Generally these patients received more severe injury than the penetrating group. The most frequent manifestations of thoracic injury were again hemothorax (43 cases), pneumothorax (48 cases), and hemopneumothorax (112 cases). Many had associated fractures of the ribs, clavicle, sternum, and scapula. Cardiac injuries were uncommon (nine cases). There were no esophageal injuries directly related to trauma. Shock on admission was a grave prognostic sign. Fifty per cent of 75 such patients died despite vigorous treatment.

The treatment followed the same general plan as outlined for the penetrating injuries. The blunt trauma group had a greater number of flail chests, segmental rib fractures, and paradoxical respirations. Rarely was open thoracotomy required.

Specific Treatment Conservative

In general the specific treatment was the most conservative that absolute safety would allow. If thoracentesis would accomplish the same as closed thoracotomy, the former was employed. Tracheos-

tomy was useful to control secretions and reduce dead space, being used in 43 cases. In the crushed chest, stabilization of a non-fixed portion of the thoracic cage is best accomplished by the use of sandbags, skeletal traction, or soft tissue traction in selected cases. If these methods fail, respirators should be employed.

In the treatment of any chest injury, cardiac injury must be considered. This is in particular reference to pericardial tamponade. In our experience most of these patients can be satisfactorily treated by pericardiocentesis.

The mortality rate in the group with blunt trauma was 21.8 per cent. Again, shock was the gravest sign.

The overall mortality was 7.7 per cent in this series.

Peripheral Arterial Injuries

Dr. John I. Dickinson: The presenting findings in these patients vary from a pulseless, obviously ischemic extremity, to a normal extremity with good pulses. When there is a palpable pulse the presence of a pulsating hematoma, bruit or thrill may serve to help in the diagnosis. Frequently it is necessary to explore these wounds in order to make the diagnosis. Often patients, who were not thought to have arterial injuries clinically, are found to have them at the time of debridement, especially shotgun wounds. Other causes of the cold, pulseless extremity must be considered. Fracture with compression, bleeding with compression, and spasm due to massive injury can all produce ischemia. Many patients are explored on suspicion alone and a large percentage are found to have major vascular injuries. The use of arteriography has been found to have a definite but limited use in this problem. Occasionally patients who do not appear to have an arterial injury and have no other indications for an operative procedure receive arteriograms.

By far the best method for controlling hemorrhage in these patients is the use of compression over the point of bleeding, hoping that there will be some collateral flow preserved. This should not be applied like a tourniquet. The tourniquet should be used only as a lifesaving measure. Great care should be exercised when clamping the vessel with a hemostat to avoid unnecessary arterial injury or damage to adjacent structures.

In arterial injuries the treatment of shock alone is not sufficient. The patient's blood volume must be restored to as near normal as possible. This plays a major role in the failure of reparative procedures due to spasm and clotting. Vasoconstrictors are

contraindicated. Immobilization of these extremities at or below heart level is important, especially when associated with a fracture. If a fracture is present, it should be reduced as soon as possible. This frequently re-establishes blood flow. The maximal interval between injury and safe, satisfactory restoration of blood flow is not known. Attempts at restoration are probably indicated until signs of ischemic necrosis or demarcation are present, even as late as 24 hours post injury.

The anesthetic of choice is one which gives good muscle relaxation and sympathetic blockage to the extremity. Brachial blocks and spinals are well suited for this, but unfortunately due to the presence of decreased blood volume, intoxication or lack of cooperation frequently cannot be used. At operation proximal and distal control are obtained before disturbing the area of expected vascular injury. Tourniquets are rarely used. Only in cases of stab wounds which are smooth and small is it possible to simply suture the artery without compromise of the lumen. In most cases it is necessary to resect a short segment and carry out an end-to-end anastomosis. It is imperative that a good flow of blood be obtained both proximally and distally prior to performance of the anastomosis. It is usually possible to resect as much as two centimeters without interrupting collaterals and creating too much tension at the anastomotic site. Intima to intima closure is carried out with a continuous everting suture. Anti-coagulants are not generally used. Procaine is frequently helpful as an antispasmodic as is periarterial sympathectomy. The use of a graft to bridge a defect is occasionally necessary. Our grafts are knitted, crimped teflon. The patient's blood volume should be near normal at the time the vascular clamps are removed. This prevents hypotension and clotting.

It is the aim in any arterial repair to establish a pulsatile flow. It may be necessary to utilize retrograde flushing techniques to obtain this.

In the postoperative period it is essential to avoid hypotension. The extremity is kept at room temperature and is not elevated. Fasciotomy may be necessary if edema increases significantly. Reoperation is required if the pulse disappears. Amputation at the lowest viable level should be carried out if gangrene occurs.

80 Butler Street, S.E.



REPORT ON ACTIONS OF THE HOUSE OF DELEGATES

June 13-17, 1960

MIAMI BEACH

HEALTH CARE FOR the aged and pharmaceutical issues were among the major subjects involved in policy actions by the House of Delegates at the American Medical Association's 109th Annual Meeting held June 13-17 in Miami Beach.

Dr. Leonard W. Larson of Bismarck, N. D., former chairman of the A. M. A. Board of Trustees and of the A. M. A. Commission on Medical Care Plans, was named president-elect by unanimous vote. Dr. Larson will succeed Dr. E. Vincent Askey of Los Angeles as president at the Association's annual meeting in June, 1961, at New York City.

Health Care for the Aged

After considering a variety of reports, resolutions, and comments on the subject of health care for the aged, the House of Delegates adopted the following statement as official policy of the American Medical Association:

"Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and then only in conjunction with the other levels of government, in the above order. The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept and is not inconsistent with previous actions of the House of Delegates of the American Medical Association."

Pharmaceutical Issues

In the pharmaceutical area the House took two actions as follows:

1. The House agreed with representatives of the pharmacy profession that the unorthodox practice of mail order filling of prescription drugs is not in the best interest of the patient, except where unavoidable because of geographic isolation of the patient. The statement pointed out that in this process the direct personal relationship, which exists between the patient-physician-pharmacist at the community level and which is essential to the public health and the welfare of patients, is lost.

2. The House also directed the Board of Trustees to request the Council on Drugs and other appropriate Association councils and committees "to study the pharmaceutical field in its relationship to medicine and the public, to correlate available material, and after

consultation with the several branches of clinical medicine, clinical research, and medical education and other interested groups or agencies, submit an objective appraisal to the House of Delegates in June 1961." The statement pointed out that certain proposals have been made which, if carried out, might impair the future of pharmaceutical research and development, thus retarding the progress of scientific therapy. It also said that the services of the pharmaceutical industry are so vital to the public and to the medical profession that an objective study should be made.

Miscellaneous Actions

In dealing with reports and resolutions on a wide variety of other subjects, the House also:

Strongly reaffirmed its support of the *Blue Shield concept* in voluntary health insurance and approved specific recommendations concerning A. M. A.-Blue Shield relationships;

Approved a contingent appointment of not more than six months for *foreign medical school graduates* who have been accepted for the September, 1960, qualification examination;

Agreed that the American Medical Association should sponsor a *second National Congress on prepaid health insurance*;

Approved the establishment of a new "*Scientific Achievement Award*" to be given to a non-physician scientist on special occasions for outstanding work;

Approved the objectives of the A. M. A. *Commission on the Cost of Medical Care* established by the Board of Trustees and headed by Dr. Louis M. Orr, immediate past president of the Association;

Urged individual members of the Association to take a greater interest and more active part in *public affairs* on all levels;

Reaffirmed its opposition to compulsory inclusion of physicians under Title II of the *Social Security Act* and recommended immediate action by all A. M. A. members who agree with that position;

Called for a review of existing and proposed legislation pertaining to *food and color additives*, with the objection of supporting appropriate measures which are in the public interest;

Urged reform of the *federal tax structure* so as to return to the states and their political subdivisions, their traditional revenue sources;

Asked state and county medical societies to make greater use of A. M. A. *recruitment materials* in presenting medicine's story to the nation's high schools;

Requested the Board of Trustees to initiate a study of present policy regarding the required content and method of preparing *hospital records*, and

Directed the Board of Trustees to develop a *group annuity insurance* program for Association members.



editorials

Human Genetics

FOLLOWING THE ADVENT of the Mendelian concepts of heredity in the latter part of the last century, geneticists focused their attention almost entirely upon statistical interpretations of cross-breeding experiments and upon observing and evaluating changes in the higher plants, insects, mice, and occasionally in man.

Although these methods continue to be of great importance, modern research in genetics views heredity at the cellular and sub-cellular levels, making detailed studies of molecules and atoms within the cells. The genetical constitution of an individual is considered to be composed of a large number of specific functional units which are definitely inherited from his parents. Each functional unit must play a definite part in cell metabolism, must be capable of exact duplication, and must be a stable structure except in occasional instances when it will undergo sudden change. This change (mutation) results in the formation of a new unit differing in structure from the original one but totally capable of reproducing itself in its new form. Inborn differences between people are considered to be caused by specific differences in the character of these units and the variable ways in which they are combined. These differences may reside in the structure of the macromolecules such as proteins and mucopolysaccharides, in the formation of certain enzymes, in the composition of body fluids and secretions, or in the excretory products. In the final analysis, however, these differences must depend upon the biochemical characteristics of the fertilized ova from which all human beings develop. The significant differences here probably lie in the structural organization of the desoxyribose nucleic acid (DNA) present in the cell nucleus. This is a very complex molecule which is

thought to contain the genetic information which it transmits to ribose nucleic acid (RNA) which, in turn, serves as a model for building the protein of the body. The structural organization of a particular protein seems to be characteristic not only for the individual, but also for the species. It must be assumed, therefore, that the pre-existing code of information residing in the DNA of the cell nucleus is transmissible from one generation to the next; and it must also evidently be present in cells which do not at the particular time contain the protein itself. A single fertilized ovum has to contain within it all the information for the production of proteins many of which will not even be formed until several cell generations later in the development of the individual.

A minor change in the structure of a single protein can be of profound clinical and pathological significance. For example, it has been demonstrated that hemoglobin S found in sickle cell anemia differs from normal adult hemoglobin in that a single amino acid residue out of the 300 or so present in each half of a molecule has been replaced by another. This is presumably due to a mutational step in a single gene and is the smallest unit of inherited variation. It is of great interest that such a minor change in the structure of a single protein as occurs in the formation of hemoglobin S can produce a disease with such severe clinical and pathological abnormalities.

Analysis of many of the "Inborn Errors of Metabolism" leads to the conclusion that a more or less direct relation exists between the occurrence of a certain gene and the presence of a particular enzyme. When a critical metabolic pathway is markedly deficient because of the absence or relative in-

sufficiency of a particular enzyme, disease results unless an alternate pathway is available. Examples of such diseases are: Galactosemia due to a deficiency of the enzyme P-gal-uridyl-transferase; phenylketonuria due to deficiency of phenylalanine hydroxylase; and alkaptonuria due to deficiency of homogentisic acid oxidase. Overt disease may not be present until later in life. This may be seen in certain hemolytic anemias associated with some drugs and with the fava bean due to deficiency of the enzyme glucose—6—phosphate dehydrogenase. Such "Inborn Errors of Metabolism" may take a variety of clinical forms including the storage diseases, renal tubular transport defects, renal calculi, etc.

One of the most recent advances has been the discovery that Mongolism is characterized by the presence of an extra chromosome. Interesting discoveries concerning the sex chromosomes, especially

in relation to Klinefelter's Syndrome and Turner's Syndrome, have also occurred recently.

The advances made in the last few years in biochemistry, microbiology, immunology, nuclear physics, tissue culture, techniques, etc., have undoubtedly opened new pathways for great strides in human genetics. Many new discoveries will be important not only to those in research, but also to those in every field of clinical medicine. It is apparent that every good clinician of the future must have at least a superficial acquaintance with modern human genetics as part of his so-called basic science knowledge.

Edwin C. Evans, M.D.

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Delegates and Democracy

THE REPORTS and actions of the House of Delegates as published in the June issue of the *Journal* represent the views of the medical profession of Georgia on current issues in the year 1960. The body of men who comprise the House can speak with authority, for collectively they represent every physician in the state.

The House of Delegates is the legislative branch of the Medical Association of Georgia, in which major actions of the Association must be approved. This body constitutes a democratic form of government, the success of which depends on individual initiative and active participation. Every member should be familiar with its formation and operation.

The House functions like the House of Representatives of the Georgia General Assembly and the U. S. Congress. It is presided over by a Speaker elected by the Representatives or Delegates. The number of Delegates allocated to a particular County Medical Society is based on the active membership of that society.

However, even the smallest society is entitled to at least one delegate. It is a matter of concern that

some of the smaller societies do not avail themselves of such representation.

The House has "Reference Committees," similar to those of the Congress and the State Legislature which study resolutions and reports that have been submitted to them. These Committees diligently investigate the various matters referred to them. Frequently, officers of the Association, Committee Chairmen and others are called before the Reference Committees to furnish specific information and clarification not contained in the Reports and Resolutions.

After the Committees have completed their study, they submit a report of their recommendations back to the House for final action.

Reference Committee recommendations may be changed by action of the House and, of course, this final action of the House is what constitutes binding MAG policy.

Each delegate attending the sessions of the House must carry a "Credentials Card" signed by his county society secretary to demonstrate to the Chairman of the Credentials Committee that he is the duly

EDITORIALS / Continued

authorized representative of that Society.

The selection of a delegate by informal methods, as is unfortunately sometimes the case, should be discouraged. This responsible job should be assigned to one of the most active leaders in the Society. He should be a physician who is conversant not only with the past actions and policies of his own society, but also with the problems of medicine generally in his area of the state.

Soon after his return from meetings of the House, it is extremely important that the delegate present a full report of its actions to the members of his local society, who are, in a sense, his "constituents."

This year the actions of the House covered a wide range of subjects which included nursing shortage, sterilization laws, social security for physicians,

fluoridation, Blue Cross-Blue Shield coverage for mental illness and many other matters. These policies have now been entered into the permanent records of the Association, and they will remain binding unless changed by some future session of the House.

Between sessions of the House, MAG Council can act for it along the lines of policy already established by the House. Actions of the Council are then ratified or disapproved at the next session of the House.

All of this legislative process cannot be effective unless individual members of the Association take an active interest in the issues and problems facing the House. Every effort should be made to elect competent and industrious delegates who will adequately represent you and your society at the meetings of the House of Delegates.

J. Frank Walker, M.D.

AHA REQUIREMENTS FOR HOSPITALS EMPLOYING FOREIGN GRADUATES

HOSPITALS EMPLOYING GRADUATES of foreign medical schools who fail to meet certain requirements by December 31 will face action by the American Hospital Association.

At that time, the AHA will cease listing hospitals which employ in patient-care situations foreign medical graduates who have not been certified by the Educational Council for Foreign Medical Graduates, Edwin L. Crosby, M.D., AHA director, said recently.

Explanation of the ruling appears in a question-and-answer pamphlet now being mailed to all hospitals which are members of the AHA.

The AHA listing program provides a national census of hospitals that meet specific requirements. Listing is not intended to be a measure of quality of care, Dr. Crosby said. However, listing is a prerequisite for accreditation by the Joint Commission on Accreditation; thus if a hospital loses its listing, it automatically loses its accreditation.

The list is published annually in Part II of the August 1 Guide Issue of *Hospitals*, Journal of the American Hospital Association.

The AHA ruling follows that of the American Medical Association, which has stated that it will withdraw approval of internships and residencies in hospitals employing foreign graduates after July 1, unless the appointees meet one of the following requirements:

Possesses a full and unrestricted state license to practice; is in his final six months of training; possesses full or temporary certification from the Educational Council; or has been given a six-month appointment

contingent on passing the September 21, 1960, examination by the Educational Council.

The Council was organized in 1957 for evaluating the qualifications of graduates of foreign medical schools. It is sponsored by the AHA, AMA, the Association of American Medical Colleges, and the Federation of State Medical Boards of the United States. The examination includes verification of educational credentials; an oral English test, and a written test of medical knowledge.

The Council was formed because of the tremendous number of graduates coming to the United States for advanced medical training and the difficulty in maintaining adequate and current information about foreign medical schools.

Considerable controversy has arisen in the last year regarding the use of foreign graduates in American hospitals. The AMA and AHA rulings are an attempt to insure high standards of patient care in hospitals, Dr. Crosby said.

Foreign graduates who are not in situations where they give direct care to the patient—research, for instance—are exempt from certification. Graduates of Canadian and Puerto Rican medical schools are considered to be graduates of American schools.

The next Educational Council examination will be September 21 and will be given in more than 50 centers in the United States and more than 60 in foreign countries. More than 4,000 individuals have passed the examination and have been certified.



mental health page

PSYCHOSOMATIC ASPECTS OF ESSENTIAL HYPERTENSION

MOST PSYCHIATRIC OBSERVERS agree that tendencies to obsessive-compulsive behavior and subnormal aggressiveness differentiate significantly hypertensives from those having personality disorders without hypertension.

The psychoanalysts propose the "psychologic conflict" theory of hypertension. They find passive, dependent, feminine, and receptive tendencies in these individuals in conflict with over-compensatory, aggressive, and hostile impulses. These latter impulses lead to fear and increase a flight from competition towards the passive dependent attitude. The hypertensive cannot free either of these opposing tendencies. He can neither freely accept the passive dependent attitude nor freely express his hostile impulses. The two attitudes block each other and a kind of emotional paralysis results.

In order to relieve anxiety and establish feelings of security, these patients suppress hostile feelings from frustrations and try to establish a passively dependent attachment to one or both parents. The fear of "parental" disapproval in retaliation for unacceptable behavior is quite marked. So is their inability to mobilize and express aggressive impulses.

Hypertensives are said to suffer from aggressive anger walled in by constraint, a conflict part conscious and part unconscious. The threatened outbreak of these aggressive impulses produces multiple anxiety symptoms in hypertensives, who cannot tolerate the loss of love that follows verbal or muscular violence.

The problem of the hypertensive individual is difficult to solve because our society defines as expected behavior for its members the responsible inhibition of aggressive tendencies.

Several investigators have noted a frequent asso-

Arthur M. Knight, M.D., *Waycross*

ciation between exposure to stressful events and the onset of hypertension. Psychological conflict is not the only necessary precondition for the overstimulation of the neuroendocrine system resulting in hypertension, but few investigators would deny that it is important.

Persons with a hypertensive makeup are recurrently and frequently inhibiting impulses to overt action. The blood pressure rises in some of these persons at such times. In time, the blood pressure rises begin to outlast the duration of inhibited impulses. Finally, hypertension is sustained instead of intermittent.

Neither the affected individual nor the observing physician may be aware of the hostile impulses which have an important influence on the blood pressure of the patient. Unresolved psychologic conflicts give rise to chronic emotional tensions which may be specifically related to hypertension. In some cases it is throttled aggression which appears to be responsible for the blood pressure elevation and in others acute anxiety. The blood pressure is apt to get better when the patient is able to give direct expression to his aggressive impulses and when his anxiety has been relieved.

Common symptoms of hypertension (headache, dizziness, fatigue, precordial pain, dyspnea, palpitation) are also symptoms in non-hypertensive psychoneurotics. It is remarkable how often the symptoms appear to be unrelated to the hypertension itself.

Blood pressure is apt to become elevated when

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situations are met which intensify chronically repressed rage without providing opportunities for adequate expression. Thus, a person with a passive personality may be caught in a family situation which produces humiliation and rage and from which he cannot extricate himself.

Rest, reassurance, and psychotherapy play a large part in the medical management of hypertensive patients, both in relieving symptoms and in lowering the blood pressure level. Airing of problems by the hypertensive in interviews with his physician may present a better perspective and allow the patient to mobilize his aggressions along more direct channels. Even though the blood pressure level may not be lowered, many of the symptoms may be relieved. A more comprehensive and more funda-

mental understanding of the hypertensive individual may often be more important than bringing the blood pressure down. We need to understand not only the high blood pressure but also the person who has the high blood pressure.

Self-directed aggression may be turned outward by the authority of the physician. Extroversion of the aggression may be of advantage to the patient. The patient may be told that inward tension which can not be relieved through action or words may manifest itself in the circulatory system by adding to the problem of hypertension. This may lead him to discuss problems which have an important bearing on the illness. Such ventilation may help relieve symptoms and point the way towards more effective release of aggressive impulses. Thus, one should encourage the patient to talk about himself as a person rather than as a medical case.

HEALTH INSURANCE FOR THE AGED

FORTY-NINE PER CENT of all Americans 65 years of age or older had health insurance protection against the costs of ill health at the beginning of 1960, the Health Insurance Association of America reported this week.

Of the 15.7 million persons in this age group, an estimated 7.7 million had health insurance, the Association said in issuing the first analysis made on a nationwide basis since early 1958 of the extent of health insurance coverage among "senior citizens."

The report was based on coverage trends revealed in government and private surveys taken during the last decade and on developments in the health insurance business.

Because of accelerated activity by insuring organizations in this area, the growth of health insurance protection among persons 65 and older during the past eight years has been at a more rapid pace than for the population as a whole, said the Association, which is composed of 270 insurance companies.

In early 1952, one out of every four senior citizens had health insurance, and now one out of two are so protected, said the HIAA. Over the same period, the growth in coverage for the total population was from nearly six out of every ten persons to a little more than seven out of ten.

In addition to the 49 per cent of the 65-and-over who now have health insurance, the Association said, another 15 per cent, or 2.4 million persons, are officially classified as indigent, and provision is made for their medical needs through Old Age Assistance, supported

by Federal-State matching fund programs. Such persons also receive money for food, housing, clothing, and other needs.

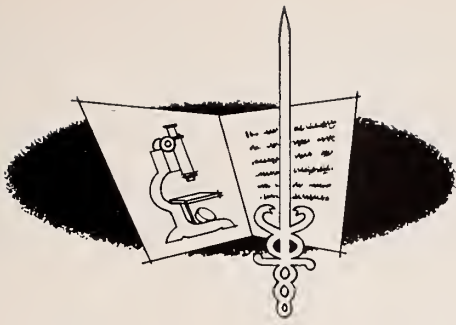
According to the U. S. Department of Health, Education and Welfare, 26 per cent of senior citizens had health insurance in March 1952, and by September 1956 this figure had grown to 37 per cent.

The most recent survey in this field was made in Spring 1958 by the National Opinion Research Center of the University of Chicago, which found that 43 per cent of senior citizens had health insurance. The rate of growth from 1952 to 1958 averaged out to a little less than three per cent a year, said the Association.

The introduction of new insuring techniques has marked the increased activity in the 65-and-over field by insuring organizations, said the Association. One technique has been the mass enrollment approach of issuing health insurance to large groups of aged persons in a state.

One company insured more than 250,000 persons by this approach alone in a 12-month period ending in June 1959.

Numerous other methods of insuring aged persons are employed, said the Association. Many of the estimated 51 million persons now covered by group insurance policies issued by insurance companies will be able to continue their insurance after retirement, generally with part or all of the premium paid by the employer. Other workers will be able to convert their group insurance to individual policies.



cancer page

CANCER OF THE FLOOR OF THE MOUTH

John Tyler Mauldin, M.D., *Atlanta*

CANCER OF THE FLOOR of the mouth includes all malignant tumors of the mucous membranes or minor salivary glands within the area bounded anteriorly by the lower gingival ridge and posteriorly by a line drawn between the anterior tonsillar pillars at the attachment of the tongue. Malignancies occurring in this area may be adenocarcinoma, arising from embryonic mucous glands or from salivary tissue. Sarcoma occurs, but it is extremely rare. By far, the most common form of cancer of the floor of the mouth is squamous, arising from the mucous membrane.

The incidence of cancer of the oral pharyngeal mucous membrane is reported at three per cent by Lawrence and Brezina and accounts for about 3,700 deaths annually. Braund and Martin in reporting the findings of 284 autopsies of patients dying from cancer of the head and neck found systemic metastasis in only 23.3 per cent. Thus one of the great challenges to the medical profession today is the control of a form of cancer that remains localized above the clavicle during its entire course in approximately 80 per cent of the cases.

Lesions of the floor of the mouth, as in other forms of cancer are more easily controlled when discovered early. For this reason physicians, dentists, and oral hygienists should develop a high index of suspicion. Any lesion that persists as long as two weeks after

the patient seeks help should be biopsied. When first seen the suspicious area should be palpated. If the lesion feels more indurated than the surrounding tissue, with a slightly elevated edge, a biopsy should be taken without further delay.

The only method of positive diagnosis is an adequate biopsy reviewed by a competent pathologist. The biopsy should be taken from the edge of the lesion to include a small portion of what appears clinically to be normal tissue. Biopsies from the ulcerated area, although easier to obtain, often show only necrotic material.

Shortly after the discovery of ionizing radiation by Madame Curie, the effects of such radiation were observed on tumors. It seemed at that time if radiation caused cancer to shrink, the proper dosage might be obtained that would produce complete disappearance. It should be recalled that during this period radical surgery, as we know it today, could not be done. Anesthesia was not safe as it is today; blood was not generally available; electrolyte balance and antibiotics were unheard of. After a period of years observers were not satisfied with the results of radiation and the pendulum began to swing toward radical surgery. Could radical surgery be employed with a reasonable mortality and not result in a socioeconomic cripple? The poorest results obtained from radiation were in those patients who had involvement of the mandible and or lymph node metastasis. Sur-

Approved by Professional Education Committee, Georgia Division, ACS.

gery has been able to salvage some of these patients and has become the treatment of choice. Surgery is more difficult following x-ray therapy because of the resulting sclerosing of the blood vessels which tends to prevent healing of skin flaps resulting in sloughing and salivary fistulas. Also in those individuals unfortunate enough to have recurrences, additional sur-

gery or a therapeutic dose of x-ray can still be used. For these reasons there is a tendency to use surgery in the early lesions as well as in the more advanced.

The argument as to whether a prophylactic neck dissection should be done at the time of surgery is not settled. It is felt at the present time that the magnitude of the initial operation is such that definite evidence of metastasis should be present to justify the additional risk of a neck dissection.

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Legal page

MEDICAL RECORDS IN GEORGIA TRIALS

John L. Moore, Jr., *Atlanta*

MEDICAL RECORDS ARE ADMISSIBLE, if at all, in trials taking place in Georgia courts under the provisions of Georgia Code Annotated § 38-711, passed by the General Assembly in 1952:

"Any writing or record, whether in the form of an entry in a book or otherwise, made as a memorandum or record of any act, transaction, occurrence or event shall be admissible in evidence in proof of said act, transaction, occurrence or event, if the trial judge shall find that it was made in the regular course of any business, and that it was the regular course of such business to make such memorandum or record at the time of such act, transaction, occurrence or event or within a reasonable time thereafter. All other circumstances of the making of such writing or record, including lack of personal knowledge by the entrant or maker, may be shown to affect its weight, but they shall not affect its admissibility. The term 'business' shall include every kind of business, profession, occupation, calling, or operation of institutions, whether carried on for profit or not. This § 38-711 shall be liberally interpreted and applied."

The Federal Law of Evidence has a statute which reads almost exactly the same as the Georgia statute. 28 U.S.C.A. § 1732. However, as many doctors who have sat through trials will know, the courts in Georgia have been very reluctant to follow § 38-711 and prefer, if possible, to construe that section rather narrowly and to exclude a medical record unless the person who made the record is present and can testify to the creation of the record. In *Knudsen*

v. Duffee-Freeman, Inc., 95 Ga. App. 872 (1957) the plaintiff had fallen down defendant's stairs. In the trial of the case the defendant introduced a 15-year-old U.S. Employees' Compensation Commission file which had in it a letter from a medical doctor to the Commission giving his opinion that the plaintiff was a malingerer. The Court of Appeals held that such record was not admissible in evidence.

In the 1958 session of the General Assembly, that body adopted a resolution reading in part as follows:

"Whereas, the Court of Appeals of the State of Georgia on May 23, 1957, by its interpretation in the . . . [*Knudsen* Case] seriously limited the meaning, effect and legislative intent of Section 38-711; and

"Whereas, in the enactment of said Section 38-711 it was the intent of this body that said Act be given a broad and liberal interpretation in order to simplify the trial of cases and eliminate the inconvenience and expense of calling into Court as witnesses those whose record of events, were made and recorded at the time of the happening of such events, and were otherwise shown to be creditable, and were properly vouched for and identified as required by Section 38-711 . . ."

The resolution went on to reemphasize that the intent of the Georgia General Assembly was that § 38-711 should be given a liberal interpretation so that such records would be admitted in the trial of cases.

Shortly after the resolution was passed the Court

Prepared at the request of the Medical Association of Georgia. Mr. Moore is an associate in the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.

of Appeals had another case called *Hawkins v. Jackson*, 97 Ga. App. 525 (1958) in which the record sought to be admitted was one of the Georgia Department of Agriculture, Veterinarian Pathological Laboratory. That record showed the examination of the chickens, concerning which the suit had been brought, with the opinion: "Indication of C.R.D." The Court of Appeals, without mentioning the resolution of the General Assembly, held that such pathological record should be excluded.

In 1959 the Supreme Court of Georgia appeared to have the final say in the debate between the General Assembly and the Court when it said that the resolution

"... made no change in Code Section 38-711, but merely declared the legislative intent. This 'is clearly an attempt by the Legislature to perform a judicial function by construing the law, and offends ... the Constitution of this State ...'"

The Supreme Court made this statement in *Martin v. Baldwin*, 215 Ga. 293 (1959). That case involved the probate of a Will with a caveat to the probate based on the allegation that the testator had suffered from monomania resulting in undue influence of named persons in the making of the

Will. At the trial those seeking to have the Will set aside sought to introduce certain records from the Veterans Administration Hospital. These records included the psychiatric history of the patient as well as the examining doctors' notes of objective manifestations and opinions.

In that case the Supreme Court went on to say that the only matters from medical records which are admissible under § 38-711 are routine facts of admission to hospital, the names of physicians, and "observable data." The Court identified as some instances of "observable data": (a) on the hospital record of examination on admission to the hospital the statement that the patient showed no signs of external injuries, or (b) a statement that the patient suffered from a deviation of the nasal septum. The Court stated as inadmissible "complicated medical diagnoses."

Thus, the doctor in Court in Georgia may expect to hear many, and probably most, medical records excluded from the consideration of the jury because they contain "complicated medical diagnoses" rather than "observable data." Needless to say, opinions may differ as to which record entry is one or the other. Especially may opinions differ among doctors and lawyers as to this subject.

HEALTH OF GEORGIA IMPROVED IN 1959

PROGRESS IN CARRYING out the 1958 statewide restaurant sanitation law, beginning of a network of poison control information centers in hospitals, further development of intensive treatment centers for the mentally ill, and developments at Milledgeville State Hospital, highlighted the annual report of the Georgia Department of Public Health for 1959.

The report, released recently, showed that with the average life span greatly increased since 1900, there is a growing new emphasis on chronic illnesses and health problems of the aging.

This is the final annual report submitted by Dr. Thomas F. Sellers as director of the Department. Dr. Sellers, who is now director-emeritus, was succeeded by Dr. John Venable at the beginning of 1960. Dr. Sellers recounted a few of the changes in public health in his 42 years with the Department, the last 12 as

director. Among these are eradication of malaria in 1938, scientific advances which made effective war on venereal disease possible, the keeping of vital records and statistics, the beginning of sanitary engineering for control of environmental sanitation, the development of public health dentistry, and the development of local health centers.

A budget of \$7,425,445 for the fiscal year 1959-60 made possible the public health services carried out in Georgia. In addition, the Department administered over \$8,604,000 in hospital construction funds, over \$4,210,000 for Battey State Hospital for tuberculosis, and \$1,508,000 for aiding crippled children. To this is added the \$10,700,000 budget of the Milledgeville State Hospital and the \$500,000 budget of the mental health intensive treatment program. A more detailed financial report is compiled for the State Board of Health at the close of each fiscal year.



heart page

THE PATHOLOGY OF "STROKE"

Heinz Bauer, M.D., *Atlanta*

THE SIMPLEST AND MOST widely accepted definition of a stroke characterizes it as "a focal neurologic disorder of abrupt development due to a pathologic process in blood vessels." This concept appears in a classification and review of the entire problem by a special committee established by the National Institute of Neurologic Diseases and Blindness.¹ In recent years interest in this common neurologic disorder has greatly increased because it can now be treated more effectively by the use of anticoagulant and antihypertensive drugs, vascular surgery and improved methods of rehabilitation. The dynamics of the cerebral circulation,² the fine structure of the cerebral arteries of all sizes^{3,4,5} the problem of the "little stroke,"⁶ the vascular lesion which causes it,⁷ and reviews of the entire problem⁸ are examples of the work in progress. Textbooks of neuropathology^{9,10} remain useful sources of information for the basic pathologic processes of cerebral thrombosis, embolism, and hemorrhage which underlie most strokes. The efforts of many multidisciplinary investigating teams are now directed towards a better understanding of these processes.

Cerebral Thrombosis

Although Fisher⁸ lists 11 causes for this phenomenon, the only one of real importance is atherosclerosis. In the cerebral arteries the disease does not differ greatly from that of the coronary vessels and elsewhere. Frequently involving the major cerebral arteries, it rarely affects those less than 0.2 mm. in

diameter. The disease results in intimal thickening and fat deposition which irregularly narrow the lumen but rarely result in complete obstruction. The latter is usually precipitated by superimposed thrombosis. Thrombosis begins as a mural clot which further narrows the vessel. Extension of this thrombotic process may explain why a relatively mild stroke may progress to a more massive stage within hours or days. In patients with hypertension the small, penetrating branches are often involved. These deep arteries have poor anastomotic channels and the chances for replacement of the blocked blood supply are bad. In contrast, the larger vessels anastomose through the circle of Willis, over the surfaces of the brain and with the external carotid system through the ophthalmic artery and its branches. As in the coronary tree, these anastomoses are more likely to develop and to provide an important alternate blood supply in cases of slow rather than sudden occlusion of a major vessel. Thus, longstanding thrombosis of a large artery may exist without neurologic deficit. Conversely, cerebral infarction may occur without thrombosis if the arterial tree is generally narrowed and blood pressure drops.

When brain tissue is deprived of oxygen even for a few minutes, irreversible damage ensues although various parts of the brain vary somewhat in their tolerance of anoxia. Infarcted areas rapidly become pale, swollen, soft and later liquefied. It is this process which is called encephalomalacia. Some bleeding may occur but is rarely of consequence. Inflammatory cells phagocytize the debris but since

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

the main supporting cells of the brain are glial, the repair tissue contains little collagen. A healed infarct, therefore, presents not as a solid scar but as a loose, cystic lesion. These can be large or may present as multiple miliary foci. The latter is seen in patients with atherosclerosis and hypertension who have narrowing of the small arteries. This picture is referred to as the "lacunar state" and these lesions probably represent microinfarcts analogous to the minute foci of myocardial necrosis in varying stages of healing which are often encountered at autopsy in the hearts of patients with severe coronary atherosclerosis.

Cerebral Embolism

Most embolic material arises in the heart. Depending on the size of the embolic particles, they may lodge in the smaller superficial cortical arteries. This may explain why strokes resulting from embolism are frequently associated with convulsions as a major sequel. Brain infarcts caused by embolic arterial occlusion also have an increased incidence of hemorrhage into the ischemic area. It is thought that the clot either undergoes lysis or moves on. This then reopens the obstructed portion of the vessel and exposes the already infarcted tissue to blood under systemic pressure with the result that hemorrhage ensues. This tendency should be an important consideration in patients suspected of cerebral emboli in whom anticoagulant therapy is contemplated.

Intracranial Hemorrhage

The subdural and subarachnoid forms are well understood. The anatomical basis of intracerebral

bleeding without thrombotic or embolic vascular occlusion is still unclear. Primary hemorrhage within the brain occurs nearly always in patients with high blood pressure and comes on suddenly without prodromal "ischemic attacks." Bloody spinal fluid due to leakage of blood into the ventricles is usually, but not invariably, present. The most frequent sites of intracerebral hemorrhage are the basal ganglia, thalamus, cerebellum, and brain stem. The escaping blood forms an expanding rounded mass which destroys tissue directly and also compresses and displaces adjacent areas. In the confined space of the posterior fossa the increasing pressure forces the cerebellar tonsils and medulla into the foramen magnum, circulation becomes impaired, and secondary hemorrhage into a vital center often leads to death in respiratory failure.

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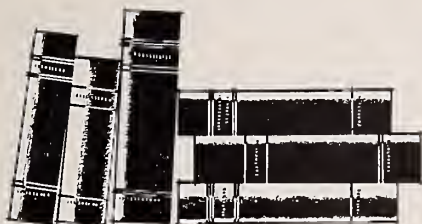
HEART DISEASE TEACHING AIDS

AS AN AID TO physician speakers, a Resource Slide Kit consisting of 188 Kodachrome and black and white slides on the subject of heart and circulatory diseases has been compiled by the American Heart Association. The complete set, including a small lighted viewer for selecting slides, is available from the Association's National Office for \$60.00, a price made possible by mass duplication.

A table of contents and descriptive material accompany the slides which are grouped for medical and for combined medical and lay audiences. Included in

the set for medical audiences are electrocardiograms, heart drawings and heart models, and cardiac silhouettes. Further information regarding the subject matter for combined medical and lay audiences may be obtained from the Association.

Mounted on standard 2 x 2 inch cardboard, the 35mm. slides come in a metal box designed to hold 300 cardboard mounted slides, thus allowing the user to add his own or additional AHA slides as they become available.



physician's bookshelf

BOOKS RECEIVED

Hilliard, Marion, M.D., *WOMEN AND FATIGUE*, Doubleday & Co., Inc., Garden City, N. Y., 1960, 175 pp., \$2.95.

Gutmacher, Alan F., M.D. and Rovinsky, Joseph J., M.D., *MEDICAL, SURGICAL, AND GYNECOLOGICAL COMPLICATIONS OF PREGNANCY*, The Williams & Wilkins Co., Baltimore, Md., 1960, 619 pp., \$16.50.

Hochberg, Lew A., M.D., *THORACIC SURGERY BEFORE THE 20TH CENTURY*, Vantage Press, New York, N. Y., 1960, 858 pp., \$15.00.

Leavell, Byrd S., M.D. and Thorup, Oscar A., Jr., M.D., *FUNDAMENTALS OF CLINICAL HEMATOLOGY*, W. B. Saunders Co., Philadelphia, Pa., 1960, 503 pp.

Moyer, John H., M.D. and Fuchs, Morton, M.D., *EDEMA, MECHANISMS AND MANAGEMENT*, W. B. Saunders Co., Philadelphia, Pa., 1960, 833 pp., \$15.00.

Millman, Milton, M.D., *PARDON MY SNEEZE*, Frye & Smith, Ltd., San Diego, Calif., 1960, 215 pp.

Proceedings of the 36th Annual Conference of the Milbank Memorial Fund, Nov. 4-5, 1959, POPULATION TRENDS IN EASTERN EUROPE, THE USSR, AND MAINLAND CHINA, Milbank Memorial Fund, New York, N. Y., 1960, 336 pp., \$2.00.

Sher, Elizabeth, M.A., Ed.D., *THE LIST METHOD OF PSYCHOTHERAPY*, Philosophical Library, New York, N. Y., 1960, 258 pp., \$7.50.

REVIEWS

Davis, Loyal, *CHRISTOPHER'S TEXTBOOK OF SURGERY*, W. B. Saunders Co., Philadelphia, Pa., 1960.

CHRISTOPHER'S TEXTBOOK OF SURGERY in its seventh edition under the brilliant editorship of Loyal Davis not only upholds the standard of excellence of its predecessor editions, but has had the able assistance of 82 outstanding American physicians and surgeons in the production of a comprehensive surgical volume laced with adjunctive medical therapy. From the introductory historical remarks by Allen O. Whipple through the easily read format of two columns to the page of print easy to read and illustrations supplied where needed to enhance the narrative descriptions, the reader proceeds through contemporary interpretations of medical therapy and surgical techniques.

The early chapters offer basic physiologic information

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

which helps the reader better appreciate the later chapters. The systems of the body are presented in the classical fashion. There are few surprises and those that do exist are pleasant indeed. The 124 pages devoted to the male and female genito-urinary system is an excellent example of the contributor's art of presentation. Sufficient information is given to provide all but the specialists in the field with details of diagnosis and treatment of diseases of the male and female genito-urinary tract.

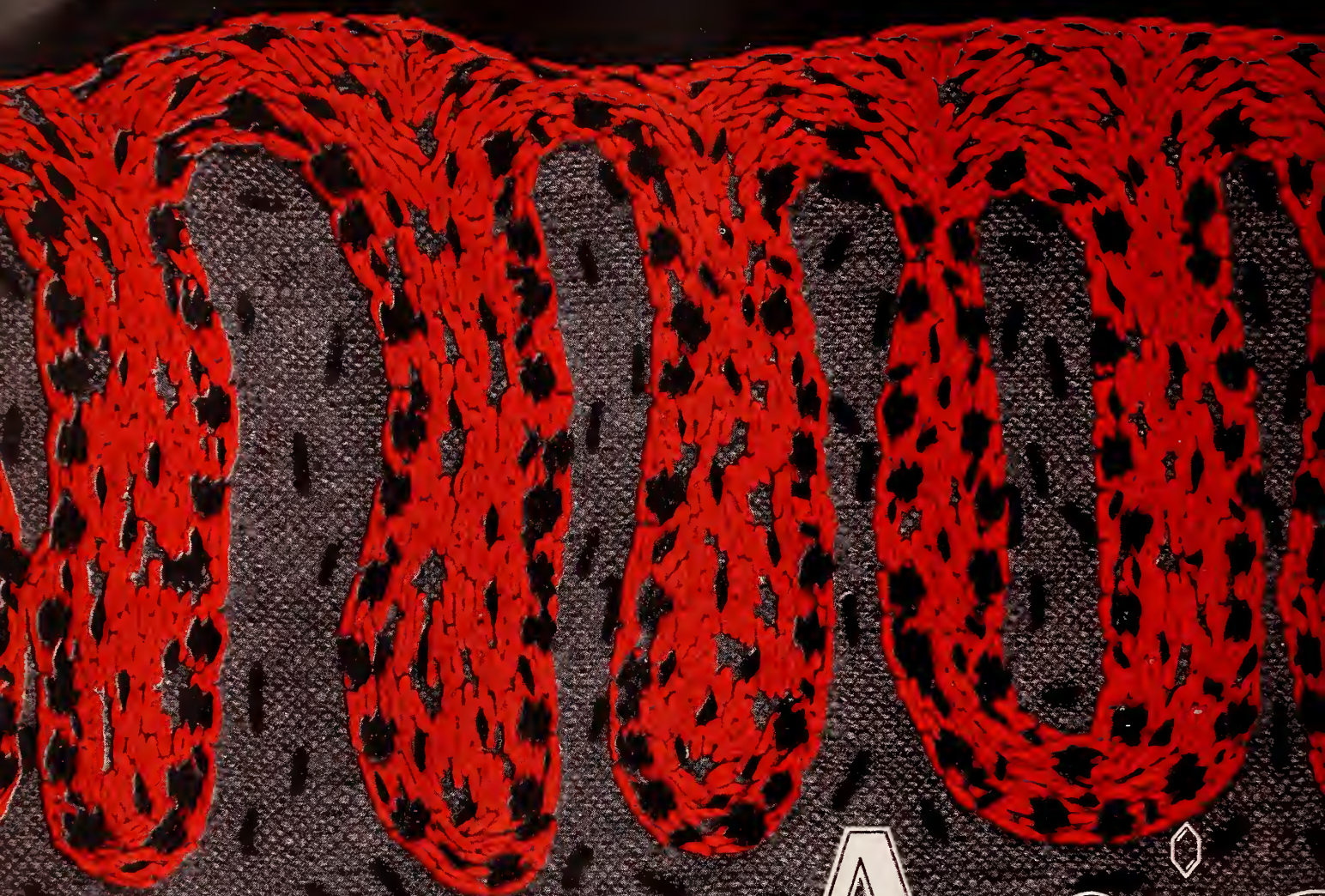
Dr. Hawley's remarks on the qualifications of a surgeon should be compulsory reading for every sophomore medical student and refresher reading for every man who calls himself surgeon. And of surgical judgment the few pages devoted to this important facet of the surgeon's personality structure is pure gold. Each chapter is replete with reading references and the index is usefully organized. No surgeon should be without a new Christopher's in his library.

Peter L. Scardino, M.D.

The Surgeon General, U.S.A., SURGERY IN WORLD WAR II, NEURO-SURGERY, Vol. II, U. S. Government Printing Office, Washington, D. C., 705 pp., \$7.00.

THIS SECOND VOLUME of neurosurgical principles as practiced in the World War II management of battle casualties, complements the outstanding contribution of the initial volume. It particularly delineates the proper management of spinal cord and peripheral nerve injuries. Very little was really known of the treatment of these conditions, based on the experience of the first world war. Many preconceived ideas were found to be unsupported in assessing the value of newly introduced surgical techniques and chemotherapeutic as well as antibiotic adjuvants. Also, the privilege of personally managing these injuries by many well trained and analytically minded neurosurgeons rapidly focused the main problems into channels of adequate therapy. The complete handling of spinal cord injuries from wound inception to rehabilitation was a new concept developed during the last great conflict which has led to our modern large comprehensive rehabilitation centers. Similarly, the introduction of the idea of very early nerve repair restored an untold number of battle casualties to normal bodily vigor, where delay would have produced frustrating total failure. This book beautifully collects many ideas which can answer any question arising

in allergic and inflammatory skin disorders (including psoriasis)

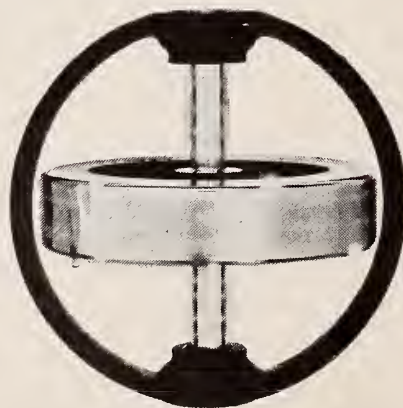


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and inflammatory
symptoms^{1-3, 7, 8, 12-15, 17, 18}



- **minimal disturbance**
of the patient's
chemical and psychic
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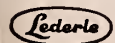
Precautions: With ARISTOCORT all traditional precautions to corticosteroid therapy should be observed. Dosage should always be carefully adjusted to the smallest amount which will suppress symptoms.

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Diacetate Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

References: 1. Feinberg, S. M.; Feinberg, A. R., and Fisherman, E. W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J. I., and Sherwood, H.: *Conn. Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S., and Friedlaender, A. S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M. S., and Duvenci, J.: *Bull. Tufts N.E. Medical Center* 4:71 (April-June) 1958. 5. Segal, M. S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Hartung, E. F.: *J. Florida Acad. Gen. Practice* 8:18, 1957. 7. Rein, C. R.; Fleischwager, R., and Rosenthal, A. L.: *J.A.M.A.* 165: 1821 (Dec. 7) 1957. 8. McGavack, T. H.: *Clin. Med.* (June) 1959. 9. Freyberg, R. H.; Berntsen, C. A., and Hellman, L.: *Arthritis & Rheumatism* 1:215 (June) 1958. 10. Hartung, E. F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Zuckner, J.; Ramsey, R. H.; Caciolo, C., and Gantner, G. E.: *Ann. Rheumat. Dis.* 17:398 (Dec.) 1958. 12. Appel, B.; Tyc, M. J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 13. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958. 14. Mullins, J. F., and Wilson, C. J.: *Texas J. Med.* 54:648 (Sept.) 1958. 15. Shelley, W. B.; Harun, J. S., and Pillsbury, D. M.: *J.A.M.A.* 167:959 (June 21) 1958. 16. DuBois, E. L.: *J.A.M.A.* 167:1590 (July 26) 1958. 17. McGavack, T. H.; Kao, K. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958. 18. Council on Drugs: *J.A.M.A.* 169:257 (January) 1959.



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PHYSICIAN'S BOOKSHELF / Continued

today regarding the treatment of these problems. In no other single reference can one find such a well documented total description of the latest methods of wound management. The editors and the office of the Surgeon-General should be complimented on the careful editing and distilled comprehensive descriptions of the thorough and completely adequate management of these conditions. This volume will not only very aptly supplement the knowledge and experience of the trained surgeon, but also, will prove to be an invaluable reference source for the less experienced practitioner.

Robert Mabon, M.D.

Delario, A. J., M.D., BREAST CANCER. The MacMillan Company, New York, 1959, 208 pp., \$7.50.

THIS VOLUME IS AN exhaustive study of the end results obtained in 465 patients with mammary cancer seen in

one institution; followed and analyzed by one physician, the author, and a radiologist.

The results of treatment in each modality within this series of cases are contrasted with both untreated cases, results obtained, and reported in medical literature. Likewise, the factors which modify the prognosis, more particularly the surgical prognosis, are dealt with in extreme detail by inclusion of 137 tables.

Unfortunately, the author's relatively small series of cases limits statistical evaluation of any significance in practically all of the various groups of types of treatment as well as the other factors modifying the prognosis.

This small monograph, though of little value as a compilation of study of the author's results, is an extremely valuable volume since it contains tabulated information concerning the important and pertinent medical literature about breast cancer.

Neil G. Perkinson, M.D.

CALENDAR OF MEETINGS

State

May 7-10, 1961—Annual Session, Medical Association of Georgia, Atlanta.

Sept. 9-10—Twelfth Annual Meeting, Georgia Heart Association, General Oglethorpe Hotel, Savannah.

Sept. 29-Oct. 1—Georgia TB Association and Georgia Trudeau Society, DeSoto Hotel, Savannah.

Oct. 12-13—Annual Meeting, Georgia Academy of General Practice, Dinkler Plaza, Atlanta.

Feb. 19-22—Atlanta Graduate Assembly, Biltmore Hotel, Atlanta.

Regional

Sept. 14-16—Southern Trudeau Society and Southern Tuberculosis Conference, Hotel Francis Marion, Charleston, South Carolina.

Sept. 26-27—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tennessee.

Oct. 31-Nov. 3—Southern Medical Association, St. Louis, Missouri.

Oct. 31-Nov. 3—Interstate Postgraduate Medical Association, 45th Scientific Assembly, Pittsburgh Hilton Hotel, Pittsburgh, Pennsylvania.

Dec. 6-8—Southern Surgical Association, Boca Raton Hotel, Boca Raton, Florida.

Jan. 16-18—Sectional Meeting, American College of Surgeons, Hotel Dinkler-Tutwiler, Birmingham, Alabama.

National

Nov. 28-Dec. 2—American Medical Association, Clinical Meeting, Washington, D. C.

Aug. 18-20—Obstetric Pediatric Seminar, Ellinor Village, Daytona Beach, Florida. (GAGP credit approval).

Aug. 21-26—American Association of Blood Banks, Jack Tar Hotel, San Francisco, California.

Aug. 27-Sept. 1—American Hospital Association, Civic Auditorium, San Francisco, California.

Sept. 1-3—Postgraduate Course in Clinical and Research Advances in Pediatrics, The Stanley Hotel, Estes Park, Colorado.

Sept. 1-6—Postgraduate Course in Pediatrics, The Stanley Hotel, Estes Park, Colorado.

Sept. 13-15—National Cancer Conference, American Cancer Society, Inc., and the National Cancer Institute, Minneapolis, Minnesota.

Sept. 24-27—College of American Pathologists, Palmer House, Chicago, Illinois.

Sept. 24-Oct. 2—American Society of Clinical Pathologists, Palmer House, Chicago, Illinois.

Oct. 2-7—American Society of Anesthesiologists, Inc., Statler-Hilton Hotel, New York, New York.

Oct. 5-8—American Academy for Cerebral Palsy, Penn-Sheraton Hotel, Pittsburgh, Pennsylvania.

Oct. 9-14—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Illinois.

Oct. 10-12—Congress on Industrial Health, Hotel Charlotte, Charlotte, North Carolina.

Oct. 10-14—American College of Surgeons, Clinical Congress, San Francisco, California.

Oct. 17-20—American Academy of Pediatrics, Palmer House, Chicago, Illinois.

Oct. 18—American Association of Poison Control Centers, Palmer House, Chicago, Illinois.

Oct. 21-25—American Heart Association, Inc., Jefferson Hotel, St. Louis, Missouri.

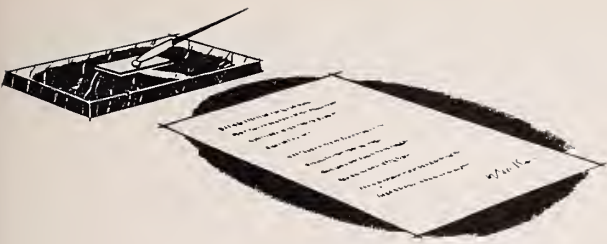
Oct. 31-Nov. 4—American Public Health Association, San Francisco, California.

Nov. 3-5—Postgraduate Course in Fractures, The Stanley Hotel, Estes Park, Colorado.

Dec. 4-9—Radiological Society of North America, Netherland Hilton Hotel, Cincinnati, Ohio.

Jan. 9-14—Postgraduate Course in General Practice Review, University of Colorado Medical Center, Denver, Colorado.

abstracts by georgia authors



Evans, Edwin C., M.D., 1211 West Peachtree St., N.E., Atlanta 9, Georgia, "Neurologic Complications of Myxedema Convulsions," *Ann. Int. Med.* 52:434-443(Feb)60.

In the past the endocrine and cardiovascular manifestations of myxedema have been emphasized with occasional mention of major psychic disturbances. Only very recently has it been pointed out that some very impressive neurological disturbances also occur in this disease.

A case is presented of a 38-year-old housewife with frequent grand mal seizures of three years duration which had led to a neurosurgical investigation including ventriculography. She was subsequently found to have primary myxedema. The seizures stopped immediately upon the institution of therapy with desiccated thyroid and did not recur over a follow-up period of four years.

Some of the factors which might affect cerebral function in myxedema are discussed.

Smith, George W., M.D.; Kemp, James A., M.D.; Farrar, W. Edmund, Jr., M.D.; Kemble, John W., M.D.; and Philpot, DeSaussure F., Jr., M.D., Medical College of Georgia, Augusta, Georgia, "Cryptococcosis of the Central Nervous System," *South. M.J.* 53:305-311(March)60.

The epidemiologic, clinical, pathological, bacteriologic, and therapeutic features of central nervous system cryptococcosis are briefly reviewed. Emphasis is placed upon previous methods of treatment developed and employed. It is pointed out that any agent that improves or arrests the course of this illness should early be brought to the attention of those physicians who see and diagnose this infection, as the ultimate clinical course has hitherto been fatal.

Amphotericin B, an antibiotic formed by a species of streptomyces isolated from soil obtained from South America has been shown in vitro and animal studies, to inhibit the growth of *Cryptococcus neoformans*. The metabolic complications of azotemia, hypokalemia, and anemia are discussed.

Four case histories of cryptococcal meningoencephalitis successfully treated with Amphotericin B are presented. The patients received approximately 50 mg. daily for seven weeks. At the end of this period cultures of the cerebrospinal

fluid became negative, and to date no organisms have been recovered by repeated lumbar punctures. All of the patients are at home at their occupations.

A long term follow-up of these cases will be required to determine the final result as regards the incidence of recurrence following treatment.

Leigh, Ted F., M.D., Emory Hospital, Atlanta 22, Georgia, "Acute Gastric Dilatation," *J.A.M.A.* 172:1376-1380(March 26) 60.

Acute gastric dilatation is a potentially grave condition characterized by clinical findings of vomiting, abdominal distention, and collapse. The probable cause for the dilatation is paralysis of the stomach, initiated by a reflex inhibition of the peripheral motor mechanism through efferent impulses which reach the stomach by way of the vagi and splanchnics. The fluid contained within the stomach is a combination of gastric juice, pancreatic juice, bile, secretions of the duodenal mucosa which reflux into the stomach, ingested material, and secretions derived from the alimentary tract proximal to the stomach. The air contained within the stomach is swallowed air. The distended stomach may in itself initiate an organic obstruction of the duodenal loop by the mesenteric vessels and the lumbar vertebrae.

Predisposing factors in acute gastric dilatation include surgical procedures, acute illness or convalescence, chronic illness, disorders or deformities of the spine overloading of the stomach, abdominal trauma and intra-abdominal accidents, confinement, and vagotomy (induced either surgically or medically). In some cases, there is no obvious cause.

Radiologic examination of the abdomen usually shows a large mass filling the upper and middle abdomen and containing both air and fluid. Contrast media by mouth may give additional information relative to the size of the stomach and the patency of the lower esophagus, at the cardia.

Treatment for this condition includes gastric suction, gastro-enterostomy, gastrostomy, gastrotomy, and gastrectomy. The poor surgical results in most instances are attributed to the condition of the patient and to the severe ir-

reversible damage in the gastric wall.

Four cases of acute gastric dilatation are presented, the predisposing factor in each being of a different nature.

Barrow, J. Gordon, M.D., F.A.C.P.; Quinlan, Carroll B., M.D.; Cooper, Gerald R., M. D.; Whitner, Virginia S., M.S., and Goodloe, Mary H. R., B.S., Georgia Department of Public Health, Atlanta, Georgia, "Studies in Atherosclerosis. III. An Epidemiologic Study of Atherosclerosis in Trappist and Benedictine Monks: A Preliminary Report," *Ann. I. Med.* No. 2, 52:368-377 (February) 1960.

A longitudinal epidemiologic study of atherosclerosis in two unique population groups has been outlined. Preliminary results indicate that the two groups, a Trappist and a Benedictine community, differ significantly in their dietary habits, especially in regard to the consumption of fats. The lacto-ovo-vegetarian Trappist group appears to have significantly lower levels of most serum lipid constituents, but on an individual basis, serum lipids cannot be correlated with fat intake alone. It was therefore concluded that most serum lipids vary on a group basis with age and dietary fat intake, but that on an individual basis there appear to be factors other than age and dietary fat which affect serum lipids.

Rutledge, Lewis J., M.D., Tulane University School of Medicine, New Orleans, Louisiana and Sigman, Cheney C., Jr., M.D., 3451 Peachtree Road, Atlanta, Georgia, "Lye Poisoning: Experiences with 95 Cases Over a Five Year Period," *Bull. Tulane Univ. Med. Faculty* 19:71-75 (February) 1960.

Experiences with lye poisoning in 95 patients over a five year period are recorded. In 87 instances the cause of lye ingestion was accidental but eight were attempts at suicide. In this series there was one fatality, and 11 patients developed esophageal strictures, requiring prolonged dilatation and hospitalization. Esophagoscopy was performed in 69 patients and appears to be the best means of early, accurate diagnosis. The prevention of this malady can be accomplished by educating parents on the dangers of lye and stronger legislation controlling the sale of this poison.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Fidler, Ardvern K.	Milledgeville Hospital Milledgeville	Active	Baldwin
Godbold, Wayne L.	35 Linden Ave., N.E. Atlanta 8	DE 2	Fulton
Grossman, Conrad P.	699 Ponce de Leon Ave. Atlanta 8	DE 2	Fulton
Harte, Ulrich A.	35 Jefferson Street Newnan	Active	Coweta
Lackey, Dixon A., Jr.	1505 Clifton Road, N.E. Atlanta 22	DE 2	Fulton
McDowell, Robert L.	1326 Gordon Street, S.W. Atlanta	Active	Fulton
Olansky, Marian F.	Emory University Clinic Atlanta 22	Active	Fulton
Perkins, James M.	69 Butler Street, N.E. Atlanta 3	DE 2	Fulton
Prieto, Edward A.	82 Baker Street, N.E. Atlanta 3	Active	Fulton
Ritchey, Sterling J.	Emory University Clinic Atlanta 22	Active	Fulton
Wiggins, Roy A., Jr.	69 Butler Street, S.E. Atlanta 3	DE 2	Fulton

QUINCY ILLINOIS DOCTORS FIGHT COLD WAR OF CLASSROOMS

DOCTORS IN QUINCY, Illinois, are deeply concerned about a vital problem facing our nation today in its race for survival against international communism—the challenge of Soviet education. They are concerned because nationwide statistics reveal that nearly half of our brightest high school students do not go on to college—which is potential leadership material lost in the educational battle that may determine the world struggle between communism and the free world. They are concerned because too few of their own profession as well as other citizen groups are taking any action to meet this challenge at the local level.

Pioneering Effort

Over the past four years the doctors of Quincy through the Adams County (Ill.) Medical Society and the Swanberg Medical Foundation have joined with other civic organizations to encourage academic achievement within their own community, and make the public cognizant of the fact that such achievement is a national resource that should not be wasted. Theirs has been a pioneering effort among medical societies, which has made the “cold war of the classrooms” a major rallying point of their whole community service program.

To date ACMS's record has been an enviable one under the Quincy Major Learning Program, established in 1956 and “dedicated to a college education for every talented high school graduate of Quincy and Adams county.” Achievements have been many and have gradually expanded over the years to include cash and certificate awards to top students of local high school

graduating classes; sponsorship of a newly organized non-profit educational program, the Society for Academic Achievement Program, which grants university loans, scholarships and fellowships to deserving students and promotes high school honorary societies for the top 10 per cent of graduating classes; financial grants to local high school teachers to attend guidance counseling workshops at nearby universities; publication and distribution of literature on scholarship opportunities.

Latest Projects

ACMS's latest action in its program to acquaint other medical societies with the great public service potential of projects of this type is a society-approved resolution to be submitted this month to the House of Delegates of the Illinois State Medical Society, recommending that “component societies be encouraged to carry on similar educational programs in their respective communities” as an example of what medicine as a profession is doing to help win the “cold war.”

ACMS has also been active in stimulating public interest and discussion on the education question by sponsoring public lectures as the recent one by Dr. E. H. Mellon, superintendent of schools of Champaign, Ill., who spoke on the topic of Soviet education.

Here is a shining example of what one small society which takes its civic responsibilities seriously can do in the realm of social action. They have provided the leadership at the local level to meet a problem of national proportions, and in so doing have gained the respect and admiration of every citizen in the community.

president's letter

WHY A MEDICAL ASSOCIATION OF GEORGIA?

THE PURPOSE of this Association, as set out in the Constitution and By-Laws, is to promote the science and art of medicine and the betterment of public health. To properly do this, good organization and the cooperation of every physician, as well as ancillary personnel, whether it be nurse, technician, educator, administrator, attendant, dietitian, engineer, etc., is required. We are all working for the same purpose—"the best of health for everyone." It is the medical profession's duty to organize, correlate, and see that all of these vast ramifications are properly functioning.

Unless there is some definite "head," chaos would prevail; consequently, the Medical Association serves this function. But this headquarters cannot function effectively without cooperation from all concerned.

You, as an individual member, are just as important to the proper and effective functioning as is the President, the Chairman of Council, or anyone else. Are you doing your part?

We have moved into the new Headquarters Building at 938 Peachtree Street, N.E., Atlanta. Why not drop by and see it? Use it? If you don't, it has not served its function. Mr. Krueger, Mr. Kiser, and their staff are there to serve you. Write them for help in your problems; write your President there and offer suggestions and make recommendations. Of course, all cannot be carried out, but each will be reviewed and evaluated. Council, which is your "voice" when the House of Delegates is not in session, meets quarterly in various sections of the State. You are invited and encouraged to visit with them when in session. Your councilor can let you know the next meeting place.

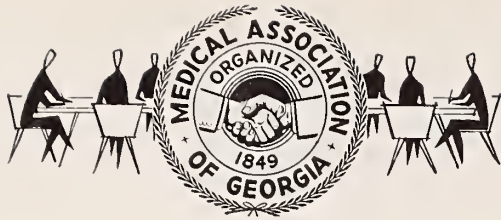
You are invited to offer suggestions to your *Journal*; Dr. Woody and his staff will appreciate your ideas for improving the *Journal*. Do you want jokes, cartoons, etc.? Serve on committees—don't wait and "let George do it." You have inherited a noble profession, which to me is the way of life for those who believe in democracy, so won't you help preserve it?

Let me hear from you as to any recommendations you have toward improving the Medical Association of Georgia.



A handwritten signature in dark ink, reading "Milford B. Hatcher, M.D.", with a stylized flourish at the end.

MILFORD B. HATCHER, M.D., *President*
Medical Association of Georgia



the association

SOCIETIES

WSB-Radio's new feature, "Tell Me, Doctor," is presented with the cooperation of the FULTON COUNTY MEDICAL SOCIETY daily, Monday through Friday.

At a recent meeting of the GEORGIA MEDICAL SOCIETY, the members enjoyed a motion picture on "Highlights of the 1959 American Medical Association Convention at Dallas."

For the first time in the State of Georgia, special science honors were given to six boys and girls, graduating from high school in the Thomas-Brooks County area, by the THOMAS-BROOKS COUNTY MEDICAL SOCIETY in recognition of high scholastic averages and scientific aptitude.

Mouth-to-mouth resuscitation was shown the LaGrange Lions Club recently in a color film made by members of the staff of St. Joseph's Infirmary, Atlanta, and given West Georgia Council, Boy Scouts of America, by the TROUP COUNTY MEDICAL SOCIETY.

The WARE COUNTY MEDICAL SOCIETY met recently to hear reports from the delegates that attended the Annual Session of MAG in Columbus.

William H. Fulmer of Savannah was recently elected president of the FIRST DISTRICT MEDICAL SOCIETY, during the group's annual meeting in Statesboro. Other officers elected included Albert Deal of Statesboro, president-elect; David Robinson of Savannah, secretary; Robert B. Gottschalk of Savannah, vice president, and Robert Swint of Statesboro, treasurer.

A meeting of the members of the FOURTH DISTRICT MEDICAL SOCIETY and their wives was held recently, the program featuring a discussion of the state's new medical examiner act.

PERSONALS

First District

CURTIS G. HAMES, Claxton, recently attended a postgraduate course at the University of Pennsylvania School of Medicine in Philadelphia.

DARNELL BRAWNER, JOHN ANGELL, PETER L. SCARDINO, ROBERT B. GOTTSCHALK, and TOM FREEMAN, all of Savannah, addressed the First

District Medical Society during the group's annual meeting.

During the Annual Session of the MAG held in May in Columbus, MILTON MAZO of Savannah was installed as president of the Georgia Pediatric Society.

Second District

J. G. STANDIFER of Blakely was recently honored by the Blakely Masons and Eastern Star.

Third District

MARY W. SCHLEY, director of the Child Development and Evaluation Center for Mentally Retarded Children, Columbus, was the speaker at the LaGrange area chapter for mentally retarded children at a meeting held in May.

DR. and MRS. E. A. MAYO, Richland, were hosts at open house and dedication of Mayo's Clinic recently.

Fourth District

J. W. CHAMBERS, LaGrange, discussed the Forand bill at a recent meeting of the LaGrange Kiwanis Club.

ENOCH CALLAWAY of LaGrange discussed various types of cancer at the May meeting of the Hogansville Kiwanis Club.

Fifth District

The new president-elect of the Georgia Pediatric Society is JOHN LESLIE of Decatur, who will head the organization in 1961-62.

WILLIAM G. HAMM of Atlanta has been named to honorary membership in the Phi Beta Kappa Society at the University of Georgia.

Piedmont Hospital has announced the approval by the Surgeon General of a Health Research Facilities grant for construction of health research facilities at Piedmont. WALTER LYON BLOOM, Director of Medical Education and Research, stated that this grant is a tribute to the hospital and its staff.

Sixth District

ZEB BURRELL and JAMES BAUGH of Milledgeville met with students at GSCW during May to discuss the requirements of medical secretaries.

Seventh District

No news submitted.

Eighth District

No news submitted.

Ninth District

No news submitted.

Tenth District

HARRY B. O'REAR, Augusta, who was recently named president of the Medical College of Georgia, introduced Dr. Julian Price of Florence, S. C., who was guest speaker for commencement ceremonies at the college in June.

DEATHS

J. G. CARTER, 75, of Scott died April 21 in Dublin after an extended illness.

Dr. Carter attended the Atlanta Medical School and interned for three years at Grady Hospital in Atlanta. He practiced medicine for over 42 years in and around Scott and was a member of the Carter's Chapel Methodist Church.

Survivors include his wife, the former Miss Avis Keen; two brothers, M. C. Carter and C. R. Carter, both of Scott, and two sisters, Mrs. B. F. Lewis and Mrs. Zack Houser, both of Scott.

JOHN H. HINES of Roswell, formerly a physician in Atlanta, died at the age of 51, May 28.

Dr. Hines was a graduate of Georgia Tech and Emory University School of Medicine. He practiced medicine in Atlanta before moving to Roswell eight years ago.

He was a member of the Fulton County Medical Society, the Fifth District Medical Society, the Medical Association of Georgia, the American Medical Association, and the New York Clinical Society. Dr. Hines was also a member of the Druid Hills Golf Club, Cherokee Club, and the Ansley Park Golf Club.

Survivors are his wife; a son, John David Hines; his mother, Mrs. C. Lopez Hines of Atlanta, and a sister, Mrs. L. A. Upshaw of Houston, Texas.

WELDON E. PERSON, prominent Atlanta surgeon for more than 55 years and professor-emeritus of Emory University, died May 14 at the age of 80.

Dr. Person started his practice in Atlanta in 1904, after graduating from the Atlanta College of Physicians and Surgeons, now Emory University. He practiced until July of last year, when ill health forced him to give up his duties.

Dr. Person was a past president of the Fulton County Medical Society, was on the staff of Emory University Hospital, and taught surgery in the Emory University School of Medicine. During World War I, he served in the army in France with a unit that had been recruited from Emory graduates.

Survivors are three sisters, Miss Agnes Person, Orlando, Fla., Mrs. Bruce Floyd, Leesburg, Fla., and Mrs. Wilber Tilden, Winter Garden, Fla.



RESOLUTION ON THE DEATH OF

DR. C. K. SHARP

WHEREAS, Almighty God, in His infinite wisdom, has translated the soul of our esteemed friend and colleague, Dr. Cyrus Kosciusko Sharp to a higher field of practice and endeavor, and

WHEREAS, Dr. Sharp, by his life and in the practice of his profession, exemplified those high ethics which characterize a great physician, and

WHEREAS, Dr. Sharp served his community and his chosen profession in the local society and the State and national associations with dignity and honor, and

WHEREAS, Dr. Sharp meant so much to his family, his home town, and his clientele for many, many years,

THEREFORE, BE IT RESOLVED by the Southwest Georgia Medical Society, that we express our deep and sincere appreciation for the life of this good man; for his high code of ethics; his devotion to duty; his uniform courtesy to his fellow physicians all down the years and for the privilege of having known him.

BE IT FURTHER RESOLVED, that we express to his wife and the other members of his family our deep sympathy in their hour of sorrow and to remind them that "Death is only a horizon and a horizon is nothing save the limit of our sight."

Respectfully,

JACK G. STANDIFER, M.D.

JAMES B. MARTIN, M.D.

TURNER W. RENTZ, M.D.

AMA MEDICAL LEGAL MEETING

EVERY TWO YEARS a legal conference for medical society representatives is convened under the auspices of the American Medical Association as part of its effort to improve interprofessional relations and as an educational program in the medico-legal field. In attendance on May 20-21, 1960, as representatives of the Medical Association of Georgia were Mr. Milton D. Krueger, MAG Executive Secretary and Mr. John Moore with Alston, Sibley, Miller, Spann, and Shackelford, MAG Counsel.

Law enforcement problems of medical quackery, AMA state legislative programs, medical disciplinary problems, and the status of anti-trust litigation were topics of discussion at the opening session.

Another part of the program was devoted to tax problems such as the current tax status of medical associations, tax deferred pension plans, unrelated business income of professional associations, and tax advantages of medical partnerships.

The last session was given to the subject of medical professional liability. More specifically, discussions concerned provisions of standard professional liability insurance policies, recent experience with foreign insurers in this field, pre-trial medical review panels, and suits against physicians as members of hospital staff committees.

Audience participation in question and answer periods

by executive secretaries and their legal counsel was a highlight of the meeting. A complete report of the meeting will be furnished the Association by the AMA and will be kept on file in the MAG Headquarters Office for the use of any MAG member on request.

1961 ANNUAL SESSION MEETING

WITH AN EYE TOWARD the 1961 Medical Association of Georgia *107th Annual Session to be held in Atlanta on May 7-10, plans and programs were discussed at an organizational meeting of convention chairmen.

Fulton County Medical Society, host society to the MAG, appointed Mark S. Dougherty as Chairman of the Local Arrangements and Linton Bishop as Vice-Chairman. Henry Tift of Macon will continue as MAG Council Chairman of Annual Session with Ted F. Leigh as Chairman of Meeting Rooms and Scientific Exhibits and M. F. Simmons as Chairman of Commercial Exhibits. Mrs. William Hopkins, as President of F.C.M.S. Woman's Auxiliary, which will be host to the state auxiliary, will serve as Chairman of the Auxiliary Liaison Committee.

Representatives of the medical specialty societies will meet later this month to program the MAG scientific section meetings. A list of these chairmen will be published in the next issue of the *Journal* as a first call for scientific papers by Georgia physicians for inclusion on the program.

The Atlanta Biltmore hotel has been chosen as the Headquarters Hotel for the 1961 Atlanta meeting and the majority of scientific sessions, the general business meetings and House of Delegates, and social functions will be held at the Biltmore.

Traditional events such as the MAG President's Banquet, Alumni Banquets, specialty society luncheons, and dinners are being scheduled to round out a full four-day meeting of the state association.

Georgia Hospital-Medical Council Meeting

THE MEETING OF THE Georgia Hospital-Medical Council was called to order at 3:00 P.M. by Chairman Milford B. Hatcher on Saturday, June 4, 1960 at the Macon General Hospital, Macon, Georgia.

Members of the Georgia Hospital-Medical Council present included: Mr. George E. Linney, Griffin, representing Georgia Hospital Association; Milford B. Hatcher, Macon and Mark S. Dougherty, Atlanta, representing the Medical Association of

Georgia; Mr. C. Woodall Bussey, Warm Springs, representing Georgia Association of Hospital Governing Boards; John T. Mauldin, Atlanta, representing the Georgia Chapter, American College of Surgeons; Fred Simonton, Chickamauga, representing the Georgia Academy of General Practice; Mr. Millard Wear, Marietta, representing Georgia Chapter, American College of Hospital Administrators. Also present were Messrs. Glenn Hogan, Atlanta, GHA, and M. D. Krueger, Atlanta, MAG. Guests at the Council meeting included Mr. Raymond Cropper, Macon and Mr. James Griffith, Director, Macon Hospital, Macon.

Members of the Council not present at this meeting included: Mr. Daniel Gay, Savannah, representing the Georgia Hospital Association; Mr. David Hamilton, Dalton, representing the Georgia Association of Hospital Governing Boards; Mr. James Sitton, Atlanta, representing the Georgia Department of Public Health; and George Hutto, Columbus, representing the medical specialty societies.

The minutes of the Georgia Hospital-Medical Council meeting of December 6, 1959 were read by Mr. Krueger and on motion duly made and seconded were approved as read.

Chairmanship

Dr. Hatcher then stated that the next order of business would be the election of the Council of a chairman, vice chairman, and the appointment of a secretary. On motion duly made and seconded, John Mauldin, Atlanta, was elected chairman of the Council. Also on motion duly made and seconded, Mr. C. Woodall Bussey, Warm Springs, was elected vice chairman. By general agreement, Mr. Glenn Hogan of the Georgia Hospital Association was appointed secretary.

Resume of Past Activity

Drs. Hatcher and Mauldin and Mr. Wear then gave a brief resume of the past activity and present status of the Council for the benefit of the new members of the Council. Also included in this resume was a report of the visitation and subsequent accreditation of the Villa Rica City Hospital, the visitation of the Forsyth County Hospital, and the scheduling of a visitation to the hospital at Bremen, Georgia on July 6.

Inspectors' Check List

The Council, after due deliberation and study, approved a check list of items to be used by the inspection team in rating hospitals (See Exhibit I). It was emphasized that this check list, as used by the inspectors, must be scored and rated by the Council before actual accreditation can be given, as previous minutes state that only the Council can accredit any hospital seeking accreditation.

Inspection Team Indoctrination Meeting

Members of the Council discussed the meeting of the 20 physician inspectors and the 20 hospital administrator inspectors. It was explained that two physicians and two hospital administrator inspectors had been chosen from each of the ten congressional districts of Georgia and that these selectees, if they so accepted their appointment, would be asked to an indoctrination meeting at which time the purpose, activity, standards, and check list of the Council would be fully explained. By general agreement, it was approved that this meeting be the responsibility of the Education Committee and on motion duly made and seconded, Mr. Millard Wear was appointed chairman of the Inspection Team Indoctrination Meeting with Drs. Dougherty and Poer as committee members. By general agreement, the meeting date was set for Sunday, July 31, with the meeting to be held in Atlanta.

By general agreement, it was approved that Mr. Wear write the hospital administrators selected as inspection team members to secure their acceptance of this appointment, and Mr. Krueger write the physicians selected as inspection team members, also to secure their participation.

There being no further business, the meeting adjourned at 5:30 P.M.

SOCIAL SECURITY COVERAGE FOR DOCTORS

AN OMNIBUS BILL approved by the House Ways and Means Committee contains two provisions of major importance to physicians—Social Security coverage for

doctors and a Federal-state program to provide health care for older persons with low incomes.

About 150,000 self-employed physicians would be

covered by Social Security on the same basis as lawyers, dentists and other self-employed professional people now are covered. Becoming effective for taxable years ending on December 31, 1960, or June 30, 1961, self-employed physicians would be required to pay a Social Security tax of four and a half per cent of the first \$4,800 of income. Physicians also would be subject to the automatic increases in the Social Security tax in future years.

Medical and dental interns would be covered for the first time also.

Rep. Wilbur Mills (D., Ark.), Chairman of the Ways and Means Committee, was the main architect of the health program for "medically indigent" aged. It was designed to provide a broad range of hospital, medical and nursing services for persons 65 years of age and older who are able financially to take care of their ordinary needs but not large medical expenses.

It would be up to each state to decide whether it participates in the program. The extent of participation—the number of benefits offered to older persons—also would be at the option of individual states.

States Determine Eligibility

The states would determine the eligibility of older persons to receive benefits under the program. However, the legislation laid down a general framework for eligibility: persons 65 years and older, whose income and resources—taking into account their other living requirements—are insufficient to meet the cost of their medical care.

The program couldn't become effective until July 1, 1961. Before putting such a program into effect, a state would have to submit to the Federal government a plan meeting the general requirements outlined in the legislation.

The program would be financed jointly by the Federal and state governments. Federal grants would have to be matched by participating states on the same basis as under the present old-age assistance formula.

States could elect to provide, with Federal financial aid, any or all of the following benefits: (1) inpatient hospital services up to 120 days per year; (2) skilled nursing-home services; (3) physicians' services; (4) outpatient hospital services; (5) organized home care services; (6) private duty nursing services; (7) therapeutic services; (8) major dental treatment; (9) laboratory and x-ray services up to \$200 per year, and (10) prescribed drugs up to \$200 per year.

The committee put a \$325 million price tag on the program for the first full year of operation—\$185 million Federal and \$140 million state. However, this estimate could hardly be more than an educated guess of sorts. The actual cost would depend upon unpredictable factors—how many states would participate how many benefits they would offer, and how many older persons would qualify and what services they would require.

The committee estimate was based on between 500,000 and 1,000,000 older persons a year receiving health services under the program. If all states participated fully, the committee said, potential protection would be provided as many as 10 million aged whose financial resources are so limited that they would qualify in case of serious or extensive illness.

Payments under the program would go directly to

physicians and other providers of medical, hospital, and nursing services.

In addition to the federal grants for the "medically indigent," about \$10 million more in federal funds would be authorized for payment to states for raising the standards of medical care benefits under present public assistance programs for older persons.

The approach of the Mills program was similar to that of Point 2 of the American Medical Association's 8-point program for health care of the aged. Point 2 stated that the AMA supports federal grants-in-aid to states "for the liberalization of existing old-age assistance programs so that the near-needy could be given health care without having to meet the present rigid requirements for indigency." Such a liberalized definition of eligibility should be determined locally, the AMA said.

Approval of the Mills plan by the committee marked a sharp setback for organized labor leaders. But they continued their all-out pressure campaign in an effort to get Congressional approval of Forand-type legislation that would use the Social Security system to provide hospitalization and medical care for the aged. After being defeated in the Ways and Means Committee, labor union leaders and other supporters of Forand-type legislation directed their major efforts to trying to get the Senate to substitute the Social Security approach.

The committee had been considering health-care-for-the-aged legislation intermittently for more than a year. Hearings were held on the Forand bill last summer but action was postponed until this year.

Prior to approving the Mills plan, the committee rejected the Forand bill (three times) and the Eisenhower Administration's far-reaching public assistance alternative. Both plans were opposed by the medical profession and allied groups.

Care of Ill Dependent Parents

While these legislative proposals were in the limelight, a little-noticed bill was enacted into law to give \$50 million in relief to taxpayers burdened with taking care of ill dependent parents.

The new law permits taxpayers full deduction on federal income taxes for medical and dental expenses paid for a dependent parent 65 years of age and older. Previously, such a deduction was limited to costs in excess of three per cent of the taxpayer's adjusted gross income.

Changes in the Social Security program called for in the catch-all bill approved by the Ways and Means Committee included:

(1) Eliminate the requirement that a disabled person must be at least 50 years old to be eligible for Social Security benefits.

(2) Provide Social Security benefits for about 25,000 widows of workers who died before 1940.

(3) Increase the benefits of 400,000 surviving children of workers covered by Social Security.

Although all these revisions will increase costs of the program, neither the Social Security tax rate nor tax base was increased.

The revisions will mark the fifth consecutive year of a national election that the Social Security program, originally enacted in 1935, has been expanded. Some of the expansions have been accompanied by tax increases.

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The Cover:

Meeting of Hospital Accreditation Inspection teams. This represents the first major meeting held in the new MAG auditorium. Photograph by Mr. Joe Jackson, Emory University, Atlanta.

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THE INTERNAL TREATMENT OF EXTERNAL DISEASES

Present day dermatologists are increasingly aware of their internal medical association and consider their skin disease problems from the systemic viewpoint.

Paul G. Reque, M.D., *Birmingham, Alabama*

MANY YEARS AGO an old cliché about skin diseases made the rounds of doctors which said, "First treat it with calamine; if that doesn't work, try sulfur; if that doesn't work, try ammoniated mercury, and if *that* doesn't work, nothing will." This sad estimate of the treatment of dermatologic disorders at the turn of this century, may still have a ring of truth in it for some of us in 1960, but the average dermatologist has progressed with his specialty in keeping with the progress of all medicine. He now is proficient in several skills, including tissue pathology, mycology, chemistry, and radiation therapy, to mention a few. In the author's medical lifetime, stress has always been placed on the viewpoint that the diagnosis and treatment of skin diseases constitute cutaneous medicine, and that the patient, as a whole, must necessarily be examined along with his skin disease. The passage of the years has served to continually emphasize this point, and if we are now living in the "chemotherapy age of medicine," surely the term cutaneous medicine fits very well.

The family physician, or general practitioner, if he prefers, has all of the skills at his disposal of specialists, although he may prefer to use only some of them, but he has a steadily mounting problem of evaluating the hundreds of new drug products placed at his disposal each year. The specializing physician has problem enough with his limited drug

specialties. It is small wonder, then, that evaluating *all* new products should present almost impossible tasks to the doctor treating all diseases.

Influx of Drug Products

The plethora of drug products each day adds to treatment problems. If we maintain an attitude of healthy skepticism for claims for them, perhaps narrow these claims down to *one* good effect from each new drug, and consider their value and cost to the patient, we may take a step toward evaluating their true usefulness.

Few skin diseases originate in the skin itself—impetigo, scabies, poison-ivy, and superficial fungus diseases come to mind immediately. Even these diseases may possibly be better treated internally today than before. Thus, it becomes clear that the proper use of internal remedies means more prompt and more certain improvement in our patient with skin disease. The tables prepared attempt in brief fashion to delineate the present usefulness of some of the new and some of the older biological and chemotherapeutic agents in readily available supply. The list is far from complete and does not imply products not listed are not to be used, but is the writer's present evaluation of more valuable remedies in his practice.

In Table I, endocrine products include the potent steroid series of drugs which play such a great part in the treatment of skin diseases today. Adreno-

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INTERNAL TREATMENT / Reque

TABLE I

ENDOCRINE PREPARATIONS
ACTH: Lupus erythematosus, acute disseminated; severe contact dermatitis; severe drug reactions.
Hydrocortisone, Prednisone® Fluorohydrocortisone: Urticaria; moderate drug reactions; nummular or chronic eczema; atopic dermatitis, occasionally.
Triamcinolone: As for 2 above; acute psoriasis-exfoliating.
Estrogen-Gonadotropin: Acne.

cortico stimulating hormone, or ACTH, given intramuscularly is particularly valuable in serious and hospitalized patients with acute systemic l. erythematosus, dermatomyositis, and pemphigus. These diseases were formerly relatively fatal over a short period of months, but the use of ACTH has extended the life expectancy to years. In lifesaving use, they have no peer, the side-effects of Cushingoid symptoms, water retention, or diabetic tendency notwithstanding. The oral counterparts, hydrocortisone, fluorohydrocortisone, Prednisone®, and prednisolone, have to some extent eliminated salt retention, and are much more useful in ambulatory patients in the treatment of self-limiting diseases such as dermatitis due to poison-ivy or drug eruptions often in conjunction with ACTH. Caution requires careful avoidance of masking concomitant bacterial or viral infection. Triamcinolone is a drug chemically related to the steroids but less useful, generally. It has been used in the treatment of psoriasis; the rebound phenomenon may be unpleasant.

The second table refers to the use of antibacterial agents. The use of penicillin needs little comment in respect to its primary value in the treatment of syphilis. It is excellent in the treatment of streptococcal infections, gonorrhea, and most Staphylococcus infections. Its unpleasant reactions are also well known. The so-called "broad spectrum series of antibiotics are also known to produce severe drug fevers and eruptions, but have a special affinity for a wide variety of gram-positive and gram-negative

TABLE II

ANTI-INFECTIVE AGENTS
Penicillins, (Synicillin®), Penicillinase: Syphilis; actinomycosis; strep. infections; penicillinase—use early.
Terramycins, Tetracycline, Chloromycetin®: With specific organisms in mind.
Nitrofurans: Newer drug—less tendency to form resistant strains?
Sulfonamides: Not less useful than before; dermatitis herpetiformis.

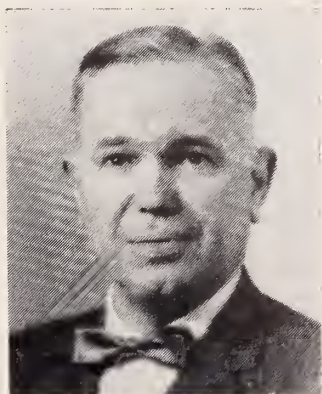
organisms. The nitrofurans also seem to be effective in both gram-positive and gram-negative organisms, with somewhat less ability to produce resistant organisms, but gastric disturbances and blood disorders are known as a result of their use. The sulfonamides, after eliminating the earlier sulfonilamide and sulfathiazole, continue to hold a major place in the chemotherapeutic field, despite their possibility of inducing sensitivity or causing drug eruptions, and must not be overlooked in the treatment of many infectious skin diseases. The easily available antibiotic sensitivity discs and culture media makes the task of deciding upon the correct anti-bacterial agent much more certain, and may eliminate the majority of reactions and production of resistant strains of organisms.

Introduction of Tranquilizers

The introduction of ataractics, or tranquilizers has galvanized the drug manufacturers into producing innumerable agents of wide therapeutic claims. If they are less habituating, they are in most instances not less troublesome in producing sun-sensitiveness, psychomotor disturbances, depressions, and liver damage. This aspect of their use requires

TABLE III

SEDATION
Sedatives: Light-reduce itching; heavy sleep and apathy.
Tranquilizers: Calms anxiety; stimulating at times; no hangover, depression, etc.
Soporifics: For sleep—many kinds and demerol for extreme cases.
Analgesics: Reduce pain—codeine; pantopon; aspirin.



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critical evaluation of their use. Abandonment of older tried sedatives such as phenobarbital and chloralhydrate with their well documented undesirable side-effects is unwarranted at this time in the opinion of the writer. Small doses in daytime, and larger doses at bedtime overcome many objectionable complaints of "hang-over," and true addiction seems to be relatively uncommon.

TABLE IV

ANTIHISTAMINES

Antihistaminics: Several types.
Antipruritic: Trimeprazine.
Ephedrine and Adrenalin
Calcium Gluconate: Autohemotherapy.

In Table IV, the antihistamine, antiallergic, and antipruritic series of drugs are considered. All are valuable in individually evaluated complaints, especially urticaria and acute allergic reactions. Trimeprazine seems especially effective if used in much greater dosage than recommended by the manufacturer, and the pruritus of chicken-pox, atopic dermatitis, and poison-ivy dermatitis may improve upon the hourly administration of this drug.

The antimalarial drugs have been used in dermatology for generations, beginning with quinine in the treatment of l. erythematosus. The more recent additions, aralen, plasmoquin, atabrine, and camoquin, have made the light-sensitive eruptions less troublesome, including l. erythematosus, but their claims of usefulness in psoriasis arthritis, molluscum contagiosum, and as amebicide begin to open our eyes in astonishment. Visual disturbances and other troublesome sequelae should be watched for particularly.

TABLE V

ANTIFUNGAL AGENTS

Griseofulvin®
Amphotericin 'B'
Mycostatin: Not internally.

In Table V the antimycotics are listed. Griseofulvin®, the newer agent, has been gratefully received in treating many true fungus diseases, notably trichophytins and microsporons of the body and scalp but it is useless in tinea versicolor and monilial paronychia of the fingers, as well as other yeast infections. Cultures of the offending organisms may aid in detecting some of the susceptible organisms, and are easily performed in most hospital laboratories. The deep mycoses are not favorably influenced by Griseofulvin®, and amphotericin only is helpful as a deterrent in most deep mycoses.

TABLE VI

MISCELLANEOUS

Antimalarials: Aralen, etc.; psoriasis, etc.
Oxpsoralens: (Meloxin®) tanning; Man-Tan®, not a sun-screen.
Aminopterin: Psoriasis, severe.
Chelating Agents: Scleroderma.
Emetine: 40 mgm. daily x 3 for Herpes Zoster (try with caution).

The miscellaneous drugs used in dermatology are innumerable, but a few deserve special mention. The oxpsoralens or "sun-tan pills" may reduce the sensitivity of the skin to sunlight, but must be used cautiously over a period of two to three weeks before unlimited exposure to sun is permitted. In vitiligo the effect is variable, sometimes excellent and permanent, at other times disappointing and transient. Side effects are minimal but caution in their use is advisable. Man-Tan®, a hydroxyacetate, is not in any sense of the word a sun-screen or protective to sunburn, and should be used as a cosmetic only.

Mention of the antimitotic drug Aminopterin® in psoriasis is made since it may cause improvement in otherwise intractable cases of psoriasis. It is highly toxic and must be used with its ill effects on the blood forming organs in mind. The same is true of nitrogen-mustard in treating mycosis fungoids. The chelating agents, sodium and potassium versenate, so spectacular in treating heavy metal poisoning, may prove of use in treating generalied or systemic scleroderma, but hospital supervision is a prerequisite.

In this brief survey of dermatologic therapy one cannot help but be impressed by the growing use of internal remedies in external disease. More and more syndromes of unknown etiology are associated with generalized phenomena eliminating the need for the term "dermatologic," and substituting "systemic," and emphasizing the medical significance of cutaneous medicine. Present day dermatologists are increasingly aware of their internal medical associations and consider their skin disease problems from the systemic viewpoint. The evaluation of internal remedies is an important part of the dermatologist's practice.

601 Woodward Building



PROLONGED TREATMENT OF ACUTE MYOCARDIAL INFARCTION AND CARDIAC ARRHYTHMIAS WITH LEVARTERENOL

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A SERIES OF RECENT publications has explored the effect of vasopressor therapy in experimental myocardial infarction in animals and also in clinical situations.¹⁻⁴ Although vasopressor drugs have been used empirically for years to prevent myocardial necrosis in patients with coronary insufficiency, their exact mode of action was not precisely understood. Corday and his associates have shown that vasopressor agents cause a redistribution of circulating blood to the vital organs during periods of diminished blood volume.¹ Animal studies have indicated that, contrary to previous observations, coronary artery flow is often reduced by many experimentally-induced cardiac arrhythmias.^{2,3} Coronary flow and coronary blood pressure closely correspond to changes in systemic blood pressure. The myocardium thus receives insufficient blood supply during many of the arrhythmias, especially when hypotension is also present.

Patients with coronary artery disease are particularly susceptible to the transient 15 per cent drop in coronary artery flow which may occur with premature auricular and ventricular systoles and which may not be significant in patients with normal coronary arteries. Such arrhythmias of vasopressors even in normo- or slightly hypotensive patients, if there are signs of cardiac decompensation, or if arrhythmias develop. Restoration of systemic blood pressure with these drugs has terminated many different types of arrhythmias by increasing coronary blood flow. Even if arrhythmias persist, pressor agents will sustain an adequate coronary flow as long as necessary and antiarrhythmic drugs may be

Levophed® appeared to be lifesaving in the control of arrhythmias complicating a myocardial infarction.

given at the same time. The systemic blood pressure should not be raised above 180 mm. Hg. systolic or serious arrhythmias may result from the vasopressor drug itself. For this reason, a short-acting, easily controlled, intravenous agent, such as levarterenol, is preferred.

In view of these observations, the case to be reported here is of particular interest. It is also noteworthy for the length of time (18 days) during which vasopressor therapy was needed.

Case Report

W.P.W., a white, male, trucksales manager, aged 50 years, was admitted to Crawford W. Long Memorial Hospital on February 12, 1958 with a diagnosis of acute myocardial infarction and arteriosclerotic hypertensive cardiovascular disease. The patient had previously been admitted in March 1957 with a cerebral thrombosis and left hemiplegia. Complete recovery occurred and he returned to work on a reduced schedule. Moderate hypertension was well controlled with Serpasil®.

In the intervening period, the patient complained of occasional mild headaches, weakness in the left upper extremity, and in frequent bouts of transient dizziness. Symptoms were not related to excessive effort or any other stressful situation.

One day prior to admission, vague upper abdominal and retrosternal discomfort accompanied

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by dizziness was noted. The pain and discomfort only lasted a short time and did not recur that day. While shaving the following morning, the patient suddenly felt weak and broke out in perspiration. These symptoms were followed by retrosternal pressure and numbness in the left arm.

Physical Examination

Physical examination revealed a well developed, moderately overweight, apprehensive white male, complaining of chest pain. His vital signs included a temperature of 99° F. and blood pressure of 160/94. His skin was warm and dry and heart sounds were of good quality with regular rhythm. Auscultation of the chest showed no rales. The patient was given morphine sulfate to relieve pain and apprehension; oxygen, and after determination of prothrombin time, anticoagulant therapy was started. Laboratory data: Hgb. 14.9 gm.; hematocrit 50 vols. per cent; sedimentation rate 8 mm.; WBC 14,800 with a differential count of 85 polymorphonuclears, 13 lymphocytes, one juvenile, and one band form of neutrophil. Urinalysis was negative. An electrocardiogram on admission showed an acute anterior myocardial infarction.

Several hours after admission occasional premature ventricular contractions developed and were treated with 250 mg. procaine amide hydrochloride, given orally every six hours. The patient did well during that day. Blood pressure was maintained at 140/80 and there was no further pain or discomfort.

The next morning (February 13) extrasystoles were still present and the dose of procaine amide was increased to 250 mg. every four hours; an immediate dose was given at 12:00 noon. At 12:45 P.M., the patient complained of feeling weak and as though he were going to faint. Respiration became labored and dropped to a rate of four per minute. He appeared cyanotic; pulse and blood pressure were unobtainable, and respiration seemed to stop completely. Immediate artificial respiration restored spontaneous breathing and a weak, irregular pulse returned. An intravenous injection of mephentermine sulfate was given for its pressor effect, followed by an infusion of levarterenol bitartrate.

Electrocardiogram Taken

An electrocardiogram taken after this episode showed runs of ventricular tachycardia, supraventricular tachycardia, and auricular fibrillation.

An intravenous Levophed® (levarterenol bitartrate) infusion containing 4 cc. of 0.1 per cent solution (4 mcg. Levophed® base/cc.) in 1000 cc. of five per cent glucose was started at a rate of approx-

imately 42 drops per minute, in an attempt to maintain systolic pressure at about 110 mm. Hg. Two hours later, the patient felt much better; cardiac rhythm was more regular, and blood pressure was 115/70. An electrocardiogram showed only auricular fibrillation and the progressive changes of a massive myocardial infarction. Oral digitalis was started with caution.

During the next six days, repeated attempts to reduce the rate of Levophed® infusion resulted in a return or increase of ventricular and supraventricular arrhythmias, though there was very little change in blood pressure.

On February 19, at 2:00 P.M., the rate of infusion was gradually reduced from 20 to eight drops per minute. Blood pressure was 112/60, but when the pulse became weak and irregular at 3:30 P.M., the rate of Levophed® infusion was increased to 12 drops per minute. A regular, strong pulse returned.

The following day at 8:00 A.M., the infusion was decreased to six drops per minute. Again extrasystoles returned, although blood pressure remained at 118/76. Levophed® was discontinued for several hours, but restarted at 6:50 P.M. the same day when arrhythmias became progressively more frequent. At 7:20 P.M., cardiac rhythm was markedly improved.

An infusion rate of 12 to 14 drops per minute was continued for another 10 days (until March 2nd) and then stopped completely with no return of arrhythmias. The patient was dismissed from the hospital on March 25th after an uneventful recovery and he continued to make good progress when seen in the follow-up clinic.

Discussion

Acute myocardial infarction in a patient with a history of arteriosclerotic heart disease was complicated by premature ventricular contractions. Procaine amide was used to correct these arrhythmias on the day of attack. Circulatory collapse occurring on the second day of treatment may have been precipitated by the increase dose of procaine amide.⁵ Alternatively, hypotension may have been due solely to the cardiac arrhythmias, which are known to reduce coronary flow and decrease coronary and systemic blood pressures.²

An intravenous infusion of Levophed® produced a rapid rise in systemic pressure and thus increased coronary flow and pressure, resulting in improvement in cardiac rhythm. Levophed® was continued for 18 days and repeated attempts to reduce or stop the infusion caused a return of paroxysmal ventricular and supraventricular tachycardias. On the 18th day, the infusion was stopped and normal sinus

ACUTE MYOCARDIAL INFARCTION / Germain

rhythm was restored. Minor fluctuations in blood pressure throughout this period did not appear to influence the course of arrhythmia.

The unusually long period of continuous vasopressor therapy is worthy of further comment. The longest infusion time with subsequent recovery of the patient was reported by Hall.⁶ He treated a patient in shock of unknown etiology with a high concentration of Levophed® for 22 days. Recovery was complicated by a large skin ulcer due to extravasation of the drug at the injection site. Tissue necrosis is not invariably associated with prolonged infusion as shown by our own and other's experience. Heller treated a patient in shock accompanying an acute myocardial infarction for three weeks using large doses of Levophed® and tissue damage did not occur.⁷ With adequate care, the incidence of tissue damage can be lessened.⁸

A continuous Levophed® infusion was given to a patient in postsurgical shock for 42 days, the longest period on record.⁹ The patient died and at autopsy myocardial damage was seen. Such experience adds support to the warning given by Corday³ that excessive blood pressure levels should be avoided, especially in a patient with known coronary disease. If the blood pressure is carefully controlled, cardiac arrhythmias and permanent myocardial damage are unlikely to develop.

Summary

Sudden circulatory collapse in a patient after an acute myocardial infarction was treated with an al-

most continuous intravenous infusion of 4 cc. of 0-1 per cent Levophed® in 1000 cc. of five per cent glucose for 18 days. Supraventricular and ventricular tachycardias were eliminated. Cardiac rhythm became regular when the blood pressure was restored and maintained within normal limits. There were no local complications from the prolonged infusion. The case is discussed in relation to recent experimental and clinical studies dealing with the treatment of cardiac arrhythmias.

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OPEN HOUSE FOR STATE HEALTH BUILDING

OPEN HOUSE for the new office building of the Georgia Department of Public Health was held June 22.

The white marble building at 47 Trinity Avenue completes an entire block of similar state office buildings next to the State Capitol. There are nine floors in the new building, including basement and sub-basement. In addition to office space, the Health Department's new headquarters houses a parking garage, cafeteria, and laboratory facilities—including special quarters for animals used in laboratory tests and experiments.

The three divisions of the Department, Administration and Finance, Physical Health, and Mental Health, include the following major areas of service: dental health, environmental health, laboratories, local health, organization, health conservation, preventable diseases, and special services.

The first office of the Department was a basement room of the State Capitol in 1903. As one can see by the picture of the new office building, many advances

have been made by the Health Department since it was first organized.



The new building that now houses the Georgia Department of Public Health is located at 47 Trinity Avenue, S.W., Atlanta.

THE PROCESS OF REFERRAL FOR PSYCHIATRIC CONSULTATION IN PEDIATRIC PRACTICE

A plan is suggested whereby the referral of a pediatric psychiatric patient is made much easier for the pediatrician.

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THE MANAGEMENT OF psychiatric problems in children is a complex and rather difficult enterprise. The disturbance is in the child but usually he is not complaining. The parents often complain about the child's behavior; they also have the responsibility for him and concern for his welfare. On the other hand parents have a very human need to protect themselves against some of the unpleasant facts of life. The thought of failure in one's child and the idea that one may have unwittingly contributed to the failure are painful, to say the least. Pain of this sort calls forth psychological mechanisms as a protective measure. Parents have a responsible concern for their child's welfare, yet are apprehensive about what a discussion of the problem might uncover. So they approach the pediatrician for help with mixed feelings.

Some of these cases he wishes to refer for psychiatric consultation. At times referral is not easy. Some of the variables involved will be discussed in this paper.

The problem is usually presented as one particular complaint. This may be objectionable behavior such as: disobedience, dawdling, hyperactivity, aggressiveness, bed wetting, or sleep disturbance. School problems are frequent: poor grades, clashes over homework, and misbehavior in school. Repetitive behavior such as: nail biting, hair pulling, thumb sucking, and facial grimacing occur. There are more obviously psychological problems such as: anxiety

attacks, fears, phobias, phobic reaction to school, and night terrors.

The chief complaint is very distressing to the parents. They struggle with it over a period of time, months or years. During this period all manner of remedies are tried. These are usually efforts aimed at controlling the particular behavior. There are frequent discussions with family, friends, clergy, and physicians.

The main complaint, the most conspicuous symptom, is the usual topic of these discussions. Less attention is paid to other areas of the child's life. What appears like "tubular vision" is one of the mechanisms needed for the parent's protection against painful realizations. There are other defensive mechanisms: placing the blame on others, optimism, and hope ("he will outgrow it").

During all this time of struggle, affairs do not improve. This appears like an incubation period. Meanwhile the pressure of circumstances may boil the kettle a little faster. Complaints from school, neighbors, comments of friends and relatives jog the parents. Also, they see that their child is not doing like the others of his age. At some point in this period of incubation, the parents conclude that something more must be done and turn to the pediatrician for help.

Examination

When undertaking the study of a psychological problem, it is important to have a definite plan of procedure. The following is submitted as a suggested program which may be abbreviated or expanded as needed. The plan will be presented as a

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PROCESS OF REFERRAL / Kiser

series of appointments, actually the timing of each phase and its duration will vary.

At the first appointment a brief statement of the general problem is obtained. The physical examination of the child is important with special attention to his general health and neurological status. This is a good opportunity to talk with the child alone. He may contribute a great deal or he may be quite guarded. There may be evidence of unhappiness, fearfulness, a dearth of satisfying activities and relationships. He may have a feeling that "he can't win." He may show a too childish unconcern for his responsibilities and poor motivation for school work. On the other hand he may be excessively conscientious, appearing as a little lady or little gentleman, over-trained and lacking the sparkly spontaneity of a child.

A second appointment is made at a time when both parents can be present, and when there is sufficient time for the interview. It is very important to defer the appointment until the father and mother can both be present. During this interview, information is obtained about the problem: description of the main complaint, onset, duration, context in which it occurs, and remedial efforts. Other evidence of maladjustment is sought, such as difficulty in coping with routine daily tasks including homework, lack of wholehearted enjoyment of play and recreation, and difficulty in developing relationships with others.

There is a certain amount of strategy in this plan. Both parents are present and take part in the conference. The history is elicited in a matter of fact way, and the physician remains neutral and does not express any judgment about the data. The inquiry is limited to statements about the child. This pattern tends to keep the interview on a factual level. At this stage in the process it is important to avoid a flood of emotions from the parents, and any such tendency is tactfully discouraged. It is important not to give advice about any of the symptomatic behavior at this time. The parents can be told at the time of the report explanations and recommendations will be made.

Provisional Diagnosis

The examination will yield a cluster of symptoms which indicate the presence of a disorder and its probable nature. The severity of the disorder can be estimated by the effect it has on the child's total living. These and other matters enter into the decision as to consultation.

A third appointment is arranged with the parents to discuss the findings. This affords an interval for

the pediatrician to think it over and time for the parents to digest the information brought out in the examination. When the decision has been made to request consultation, the referral can be presented at this third appointment.

Report

The material brought out in the examination is now presented in more organized form. It is pointed out that this cluster of symptoms is evidence of an emotional disturbance. It is explained how these symptoms are derivatives of the basic emotional conflict. Here is a rather early stage of a neurotic process which causes the child to need to develop symptoms. This neurotic core is an obstacle to his subsequent development and interferes more or less with his happiness, efficiency, and relationships with family and friends. Questions and discussion about this material are appropriate here.

Referral

As mentioned the parents have been going through an evolution in their attitudes about their child, somewhat groping toward understanding. The physician has now joined with them in this effort. He has studied the problem with them, looking over their shoulders so to speak. His professional investigation has gone through a sequence moving from random complaints to more organized facts to a rational perspective. There is need for further evaluation of the child's basic emotional disturbance. The referral for psychiatric consultation now comes as a logical suggestion. Consultation is for a limited purpose—for further evaluation and recommendations.

Return Visit

After the psychiatric consultation, it is important to schedule a return visit with the family. The pediatrician plays an important role in the child's subsequent course. It is helpful to discuss the consultation and let the parents know of his continued interest.

Summary

The parents of a child with psychiatric disorder go through a period of distress and random efforts to cope with the symptomatic behavior of the child. This resembles an incubation period. A variety of people play a part in helping the parents "get good and broke out" as is said of measles.

The pediatrician brings an important force to bear upon the parent's random efforts. A plan is suggested whereby he helps them to a broader understanding of the child's problem. The pediatrician is then in a good position to suggest psychiatric consultation.

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J. M. A. GEORGIA

GRAVITATIONAL PLACENTOGRAPHY IN MANAGEMENT OF PLACENTA PRAEVIA

Robert B. Quattlebaum, M. D., *Valdosta*

This method relies entirely on plain radiographs and is devoid of discomfort or danger to the patient.

THE RADIOLOGICAL LOCALIZATION of the placental site has been the subject of considerable research in recent years. The primary indication for the performance of placentography is the clinical suspicion of the presence of placenta praevia. This condition carries such great potential danger to both mother and fetus that early and reliable diagnosis is most important. In many instances of emergency admission with antepartum hemorrhage the clinical position is such that no radiological assistance is required or desired. The maximum value of the radiological method is that it permits a preliminary selection from the cases suspected of having placenta praevia. A decision whether or not admission is necessary can often be made on the radiological support or opposition to the provisional clinical diagnosis.

Numerous methods of radiological investigation of placental sites have been advocated. These include direct amniography, intra-arterial amniography, radioactive localization, and tomography. For a method to be widely accepted it must be simple. Because of the present knowledge concerning potential radiation hazards to the fetus, the x-ray investigation should be limited in extent.

We have made no innovations in technique but are closely following that first described by Reid¹ and expounded by Hodge.² The method is based on two principles: (1) The direct visualization of the soft tissue shadow of the placenta, which can be ac-

complished by a single 14 x 17 lateral view of the abdomen using soft tissue technique with a wedge filter, and (2) the position of the presenting part under the effect of gravity in its relationship to the maternal pelvic brim, which can be accomplished by a single 10 x 12 lateral view of the maternal pelvis made in upright position.

Radiological Technique

Exposure factors are shown in Table I. The examination is performed at any stage of pregnancy after the 32nd week and the patient needs no preliminary preparation except for emptying the bladder. It is absolutely necessary that the bladder should be emptied and this is best accomplished by catheterization. The patient is frequently unable to completely empty the bladder in late pregnancy and the patient should be catheterized before the examination is performed. Figure I shows the effect of catheterization upon the descent of the fetal head into the maternal pelvis on upright study. It has been conclusively shown that it is not possible for plain recumbent films to differentiate between placenta, amniotic fluid, and other soft tissue densities. On recumbent lateral films crescentic shadows may be attributable to a falling away of the fetus from those parts of the uterine wall that are projected tangentially and filling of the resulting dead space by fluid. This would give a false impression of placental

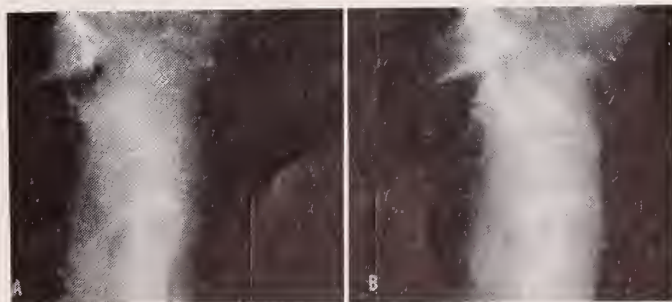


Figure 1: Figure (a) before catheterization but after voiding. Note descent of fetal head in (b) after patient was catheterized. Patient not in labor.

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GRAVITATIONAL PLACENTOGRAPHY / Quattlebaum

site. Therefore, the first film made is a lateral of the abdomen with the table tilted upright approximately 45 degrees. A brass wedge filter is used to diminish penetration of the thinner anterior abdominal wall. The filter that we have employed was "home-made" (Figure 2) and is beveled so that a gradual increase in filtration is obtained from the center of the film anteriorly and maximal filtration is obtained at the lateral margin of the film anteriorly. Since the specific gravity of the fetus is higher than that of amniotic fluid, the patient is tilted upright 45 degrees, then, if a crescentric shadow is seen anteriorly, it may be assumed to be placenta. However, if a crescentric shadow is seen posteriorly, it does not necessarily have to be placenta, although in the absence of an anterior placental shadow and with the fetal skull engaged, it probably is. Since, in the great majority of the cases, the implantation of the placenta is either on the anterior or posterior uterine wall, or at least enough of the placenta extends to the anterior or posterior walls so that its site can be determined, a routine AP film of the abdomen is not advocated. Following review of the single lateral film, in cases of doubt, a straight AP film can be obtained.

A lateral film of the pelvis with the patient standing upright determines the relationship of the fetal presenting part to the maternal pelvis. It is important to remember that the patient should be catheterized before this film is obtained. Displacement of the presenting fetal part over 2½ cm. from the symphysis pubis or 3 cm. from the sacral promontory is significant, if correlated with other features. If on the soft tissue lateral view of the abdomen the placental shadow is seen to lie on the anterior uterine wall and there is displacement of the presenting part from the symphysis pubis over 2 cm., it would indicate a segment of the placenta extends onto the lower



Figure 2: Brass wedge filter used to decrease penetration of anterior abdominal wall.

uterine segment. It has been suggested that a pendulous abdomen would allow the fetal head to move forward when the patient is upright and would give a false impression of displacement from the sacral promontory. We had the opportunity to examine numerous grand multipara with very pendulous abdomens within the last two weeks of pregnancy. In none of the cases studied on the upright lateral view was the fetal head displaced from the sacral promontory with a pendulous abdomen. It is true that the abdomen becomes rather protuberant, but the body of the fetus will be anteriorly displaced and the fetal head seems to pivot against the sacral promontory. It is emphasized that when a patient is upright the sacral promontory is considerably much more anteriorly than is commonly conceived. Hodge has made the observation that on the upright lateral view of the pelvis, if the presenting part is centered below the maternal mid acetabular level, that placenta praevia of a major or surgical degree can be excluded. We have reviewed our cases and found that this observation holds true in our series. In no cases of placenta praevia was the presenting part lower than the mid acetabular level on the upright lateral study.

TABLE I

Projection	Film size inch	Body thickness cm.	Added filtration	KVP	MAS	T.F.D. inch	Skin Dose	
							Present Mr.	Previous Mr.
Lat. abdomen	14 x 17	31	2.5 Al brass wedge	79	150	40	1,500	10,000
Lat. pelvis	10 x 12	35	2.5 Al brass wedge	85	200	40	2,600	17,000

Gonadal Dose with Present Techniques:

Projection	Maternal left ovary			Maternal right ovary			Fetal Gonads		
	% depth doses	Skin doses Mr.	Gonad doses Mr.	% depth doses	Skin doses Mr.	Gonad doses Mr.	% depth doses	Skin doses Mr.	Gonad doses Mr.
Lat. abdomen	30%	1,500	450	0.8%	1,500	12	5%	1,500	75
Lat. pelvis	30%	2,600	780	0.8%	2,600	208	Lead diaphragms used gonads out of field in cephalic		
Total dose			1,230 Mr.			220 Mr.			75 Mr.

(From Whitehouse, Walter M., et al. American J. Roent. 1958 Vol. 80: 690)

In frank breech presentation the same factors hold true and the fetal presenting part can be measured from the fetal fatline of the buttocks or thighs. The placenta must be implanted in the vicinity of the dilating zone so that it would interfere with descent of the presenting part to indicate a major degree of placenta praevia. The junction of the upper and lower uterine segment is just above and parallel to the brim of the pelvis on a line from the first sacral segment to the lower border of the symphysis pubis. The external os is in the vicinity of the ischial spines on lateral view. The amount or "bulk" of placenta seen in the uterine fundus is important in evaluating the amount of displacement of the fetal head on upright lateral study. A large placenta, by nature of its size, may extend into the lower uterine segment and be normal. If a good high placental implantation is seen with equivocal displacement of the head from the symphysis pubis, this would indicate a long thin placenta and a minor degree of low implantation. If the fetal presenting part is displaced over 3.5 or 4 cm. and a good bulk of placenta is not visualized anywhere in the uterine fundus, then a major degree or surgical degree of placenta praevia is indicated.

In placenta praevia centralis the fetus frequently assumes a transverse lie with the fetal back arched upward. The arms and legs seem to hang pendulous and point to the inferior uterine segment. This has been observed in two of our cases of placenta praevia centralis or total placenta praevia.

The presence of calcium in the placenta has been reported in some series up to 40 per cent in incidents seen in utero. We have been able to demonstrate placental calcification with much less frequency.

When it is present, however, it is of definite value in confirming the site of placental implantation.

Cystography has not been used because (a) it is useful only in anterior placenta praevia and (b) the bladder should be empty to allow normal descent of the presenting part.

Any abnormalities in the fetal head should be considered in measuring displacement. One of our errors in interpretation was made because the fetus was dead and the fetal head was collapsed and we were not actually measuring displacement of the fetal head but apparent displacement. The increase in distance between the sacral promontory and what was thought to represent the fetal skull was due to collapse of the fetal head and not displacement. It is noticed in this case, however, that the presenting part is below the maternal mid acetabular level which would exclude a major degree of placenta praevia.

Radiation Hazards

It is not our purpose to enter into controversy as to the potential danger of the genetic and somatic effects of radiation to the mother and fetus. It is worthwhile, however, to point out that the fetal mortality in placenta praevia varies from 11.9 to 43 per cent in several series of cases (Table II). By using high speed screens, the skin dose delivered can be reduced as much as 50 per cent. By obtaining only a lateral view of the maternal abdomen and a coned down view of the maternal pelvis upright, the calculated depth dose to the fetal gonads is quite low (Table 1).³ Recent obstetrical surveys indicate that the fetal mortality in placenta praevia

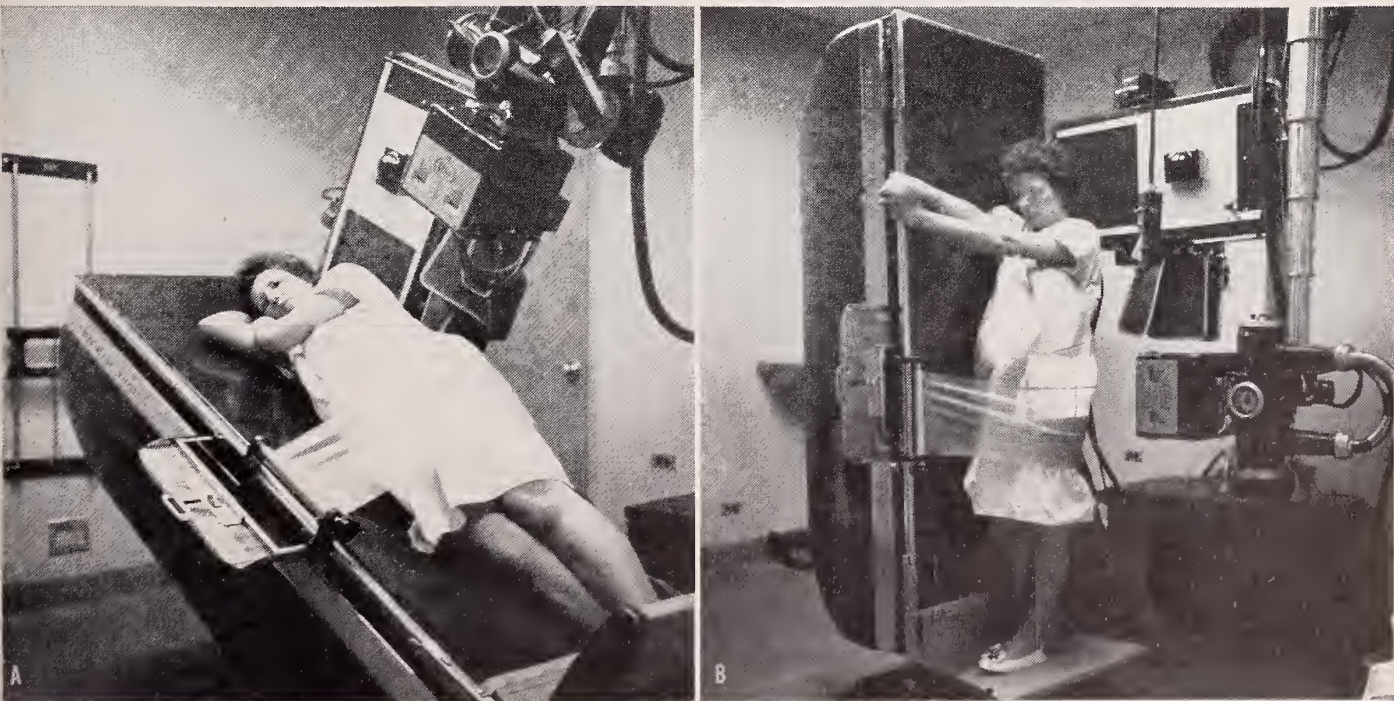


Figure 3: Patient in position (a) for soft tissue view of uterus; (b) position for lateral view of pelvis with patient upright.

GRAVITATIONAL PLACENTOGRAPHY /
Quattlebaum

TABLE II

Fetal Mortality in Placenta Praevia			
Author and years	No. of Cases	Maternal Mortality %	Fetal Mortality %
Johnson, 1939-49	211	0	30.1
Schmitz, O'Dea & Isaacs, 1941-51	112	0.89	22.3
T. W. Roddie 1933-1954	286	2.1	43.0
Paalman & Hunt 1919-45	134	1.5	23.0
MacAfee 1937-44	177	0.57	23.5
Grant, 1946-53	200	0	12.0
Heffron, 1948-58	126	0	11.9

is diminishing somewhat, but is still quite high. This decrease in fetal mortality rate is attributed to the conservative management of placenta praevia. One of the chief causes of the high infant mortality rate is prematurity. Radiological exclusion of placenta praevia in antepartum bleeding is very helpful because the expectant or conservative treatment can be followed with less risk in marginal cases and greater assurance in the definitely negative cases. A very important application of radiological diagnosis of placenta site is that it enables a diagnosis of the cause to be made in patients who have been admitted with third trimester bleeding when this bleeding is not of such severity as to demand immediate clinical investigation and treatment. It is now possible without the necessity of a vaginal examination and its attendant risk. It is no longer necessary to keep patients with antepartum bleeding but without placenta praevia in the hospital, perhaps for weeks, if one is adapting the expectant attitude advocated in obstetrical practice recently. Definite x-ray confirmation is a valuable aid in the selection of the cases suitable for this conservative treatment. If a patient is suspected clinically of having a placenta praevia because of a high presenting part, malpresentation, or hemorrhage, in most cases the provisional diagnosis can be confirmed or disproved radiographically. This can often be accomplished as an outpatient procedure. Furthermore, many patients admitted as an emergency can have placenta praevia

TABLE III

Results of Gravitational Placentography			
Grady Memorial Hospital—July 1958-June 1959			
Diagnosis	Total	Number Correct	Number Incorrect
Normal implantation. No evidence of placenta praevia.	46	45	0
Questionable low implantation. Minor degree of placenta praevia.	16	10	6
Definite major degree of placenta praevia.	16	14	2
TOTALS	78	70	8

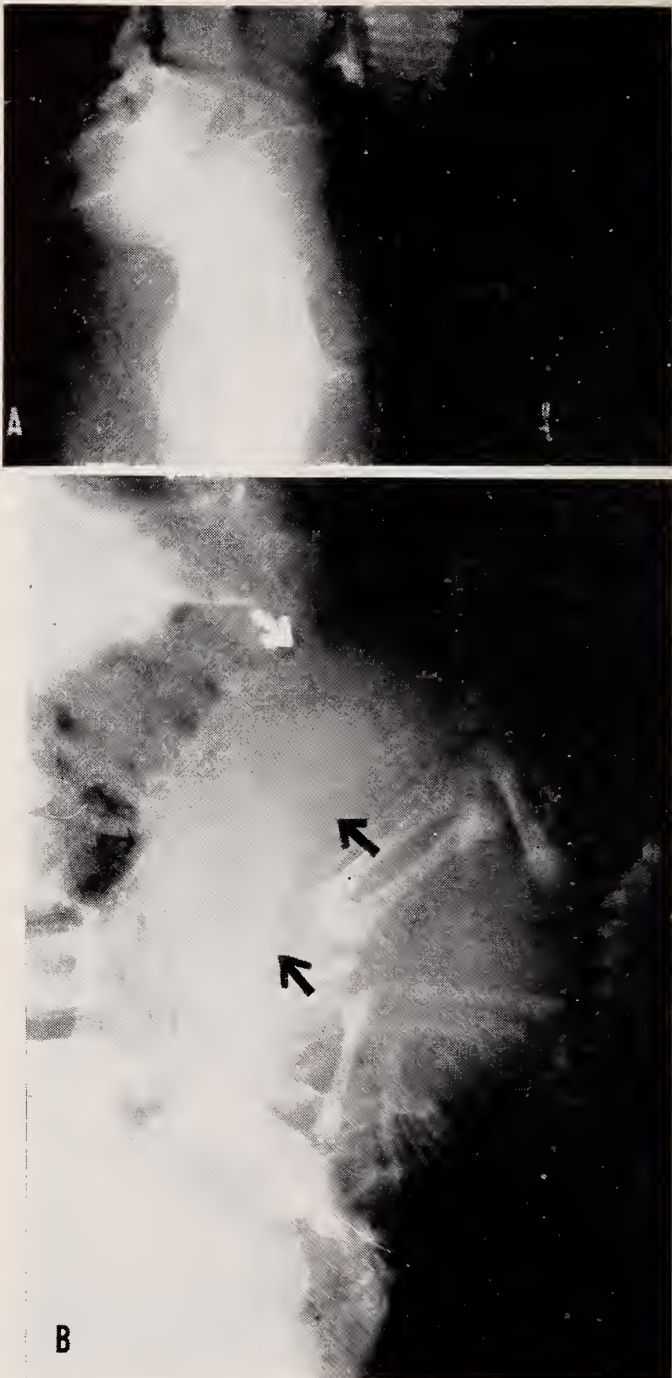


Figure 4: Normal posterior implantation of placenta. Note in (a) the proximity of the fetal head to the sacrum and that the presenting part is lower than the maternal mid acetabular level.

excluded after admission without having a vaginal examination under anesthesia. The radiologist, therefore, can aid the obstetrician in helping select those patients suitable for expectant treatment and avoiding the unnecessary hospitalization of those patients who have bled but do not have placenta praevia.⁷

Placentography: Predictions and Results

Of 46 cases of third trimester bleeding called normal implantation with no evidence of placenta praevia, all delivered normally without any further clinical evidence of low implantation. The site of placental implantation on the uterine wall which was predicted by x-ray examination was compared with the actual site at cesarean section on the proven cases.

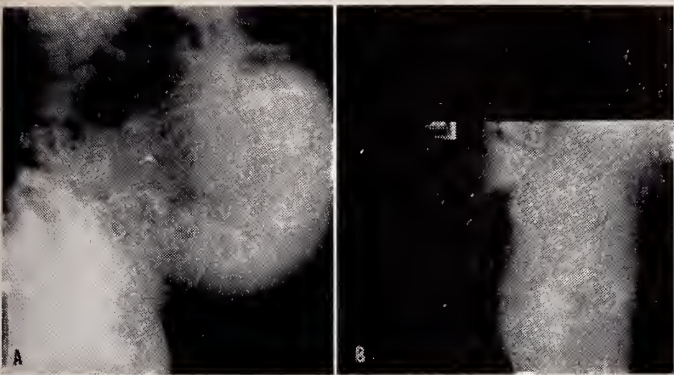


Figure 5: Anterior placenta praevia. Note soft tissue placenta anteriorly in (a). Note distance between fetal head and symphysis pubis in (b). Also note presenting part is higher than maternal mid acetabular level.

We have no way of definitely establishing the cases called normal implantation without evidence of placenta praevia because all of these patients were delivered vaginally and it is impossible to tell after vaginal delivery the exact site of placenta implantation. But we assume they were normal because none of the 46 cases required surgical intervention or even examination under anesthesia. The highest degree of accuracy seems to be in the normal implantation and in the cases called definite major degree of placenta praevia. The definite diagnosis of placenta praevia of major degree was made in 16 cases and confirmed at surgery in 14 cases. One case in error was the case previously mentioned of fetal death with collapse of the fetal cranium. When the displacement of the fetal head is significant on the upright study and a good placental shadow cannot be found in the uterine fundus, the obstetrician is advised by the radiologist that a major degree of placenta praevia is quite likely. This is of great importance to the obstetrician so that the patient can be kept under close surveillance. In 16 cases, an equivocal impression was made suggesting minor degree of placenta praevia or marginal implantation. Ten of these cases



Figure 6: Posterior placenta praevia. Fetal head (outlined by arrows) is markedly displaced anteriorly and upward. Distance to sacral promontory was 6 cm. Note fetal head is much higher than maternal mid acetabular level.



Figure 7: Placenta praevia centralis. Note transverse position of fetus. Extremities seem to hang down toward pelvis. Fetal back is arched upward adjacent to wall of uterine fundus. Arrows outline low implantation of placenta.

were confirmed by vaginal examination under anesthesia or at time of delivery. The remaining six cases delivered spontaneously without definite confirmation of marginal or minor low implantation. We have thus called these cases errors when they might not be.

Conclusion

The gravitational method of placentography combined with good soft tissue lateral views of the maternal abdomen afford a method with a high degree of accuracy. It is very simple and does not cause significant radiation hazards. This method relies entirely on plain radiographs and is devoid of discomfort or danger to the patient.

The high fetal mortality rate with placenta praevia⁵ would indicate that the potential radiation hazard to the fetus would not exceed the increased fetal mortality due to prematurity associated with early



Figure 8: Collapse of fetal head with intrauterine fetal death simulating anterior displacement of head from sacral promontory.

GRAVITATIONAL PLACENTOGRAPHY / Quattlebaum

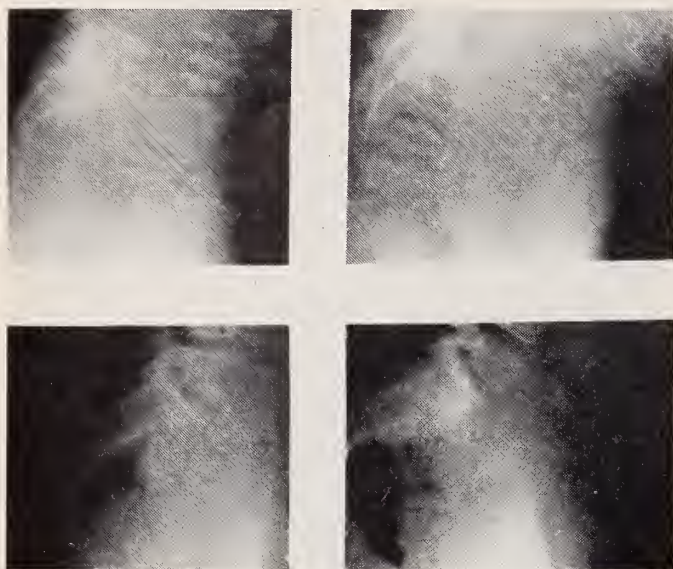


Figure 9: Four cases of posterior placenta praevia. Note the anterior displacement of the fetal head from the sacral promontory in each case.

cesarean section. A definite exclusion of placenta praevia by x-ray localization in a patient with bleeding may minimize the hospitalization of the patient and decrease the necessity of a vaginal examination

under anesthesia. When the placenta site has been excluded as being on the lower uterine segment and a soft tissue density suggestive of placenta located in the fundus, then the conservative management of third trimester bleeding with its attendant decrease in fetal mortality can be pursued with greater confidence.

Pineview General Hospital

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COUNTY OFFICIALS RECEIVE NEW COMMITMENT FORMS

COPIES OF FORMS for carrying out provisions of the new 1960 commitment law for the mentally ill were mailed July 1 from the Georgia Department of Public Health to every county ordinary in the State.

The new law became effective July 1 and the forms were designed to insure maximum use of the law. They were developed jointly by the county ordinaries, the Governor's Advisory Committee on Mental Institutions, and the Georgia Department of Public Health. They will be available from only one source—the Division of Mental Health of the Georgia Department of Public Health—which will furnish them free temporarily to see which counties use them and to determine if any changes are required. The law provides that the Department prescribe the forms, and after the temporary try-out period the counties will be responsible for their own purchases of them.

Although the 1960 General Assembly passed a new commitment law, the old law remains on the books and may still be used. The Health Department has recommended that the old law be used only if a patient being committed has assets which in the opinion of the ordinary require the appointment of a guardian. This is expected to represent no more than 10 per cent of patients committed.

Some of the changes in the new law were pointed out by Dr. John H. Venable, director of the Georgia Department of Public Health:

The term "insane" has been changed to "mentally ill," and the name of the local Lunacy Commission has been changed to Examining Committee. These verbal changes are in line with modern and more hu-

mane concepts of mental illness, and are expected to have a beneficial effect on patients and their families.

Under the new law patients can exercise all of their civil rights, which include the right to dispose of property; execute instruments; make purchases; make contracts, and vote.

A physician's certificate is required at the time of the petition to commit a mentally ill person.

The patient or his attorney or guardian must be given notice of the hearing. The attorney or guardian must waive the ten-day waiting period on behalf of the patient.

The fee paid to each member of the Examining Committee by the county of the patient's residence remains at \$10.00; the Ordinary's fee is changed from \$20.00 to \$25.00, or remains at the \$10.00, if the application is dismissed.

Patients may be admitted to hospitals other than Milledgeville State Hospital which are approved by the State Board of Health. (MSH is at present the only approved hospital other than Veterans Administration hospitals.)

Voluntary patients may be detained for three days by the Superintendent rather than 30 days under the old laws.

The patient may not be detained in a non-medical facility, such as a jail, except in case of emergency.

Other changes in the law deal with periodical re-evaluation of the necessity for hospitalization of the patient.

Voluntary admission of patients does not go through the courts under the new law.

DUHRSSSEN'S INCISIONS

This time proven procedure properly employed renders a valuable obstetrical aid.

P. C. Graffagnino, M.D., *Columbus*

IN THE PAST 15 years there has been a growing tendency on the part of our specialty to solve all complicated problems of delivery by cesarean section. The mere mention of high or midforceps, fetal distress, or version often elicits a shudder, and an immediate retreat to section as the universal solution. While it is true that cesarean section under present day optimum conditions is a relatively innocuous procedure, it still remains a major operation. As such, and especially in private practice, it imposes a considerable added financial and post-operative recovery burden on the patient.

The performance of Dührssen's incisions is also often looked upon as a reversion to medieval practices. This is an unjustified attitude toward a procedure that is useful, simple, economical to the patient, and frequently better suited to an individual case than is cesarean section.

Case Reports

In reviewing our difficult operative deliveries over the past ten years, (approximately 300 such cases out of a total of 3,000 deliveries), it was noted that Dührssen's incisions had been performed in seven cases. Following are brief summaries of these seven cases:

1. C.H.: 32-year old white female, 10 years married, six previous pregnancies all terminating in spontaneous abortion at three-five months. Induced at 42 weeks with fractional i.m. pitocin. Secondary inertia after 10 hours with cervix at 7 cms. Rest with sedation and hydration, followed by i.v. pitocin. Remained at plus two station with cervix completely effaced and 8 cm. for next four hours. (Total labor, 26 hours.) Delivered under pudendal

block, with Dührssen's incisions at 10-2 by low-midforceps. Normal 6 lb. 15 oz. infant, good condition. P.p. course uneventful. Cervix at eight weeks showed excellent healing.

2. P.H.: 24-year old white female, para 0 ab. i. Spontaneous onset labor at 42 weeks. Inertia after 18 hours labor with cervix 4 cm. dilated, 95 per cent effaced; rest with sedation and hydration. Good labor resumed six hours later. Pelvimetry showed no disproportion, OP position with extension and asynclitism. After 10 hours more of labor, cervix completely effaced 7 cm. dilated, plus one station. Delivered under pudendal block with Dührssen's incisions at 10-2. Low midforceps rotation (Scanzoni). Seven pounds 6 oz. infant good condition. P.p. course uneventful. Cervix well healed at 10 weeks.

Subsequent pregnancy 18 months later. Ten hours labor with 30 minute second stage, outlet forceps. Cervix intact. Third delivery 14 months later. Eight hours labor, spontaneous delivery; cervix intact.

3. H.K.: 24-year old white primigravida. Onset spontaneous labor at 41 weeks. Primary inertia. Pelvimetry normal, OP position, military attitude. After total of 28 hours labor, cervix 8 cms., completely effaced, plus two station. Delivery under general. Low midforceps rotation (Scanzoni), Dührssen's incisions at 10-2-6. Eight pounds 4 oz. infant, good condition. Cervix well healed at 10 weeks.

Subsequently delivered in Louisville, Ky. two years later. Twelve hours later, spontaneous. No complications.

4. E.W.: 18-year old white primigravida; obese. Elective induction at term for severe preeclampsia. Primary inertia. No disproportion, OP position. After 30 hours labor cervix 7 cms., completely effaced and plus one station. Delivery under general and block. Low midforceps rotation (Scanzoni) Dührssen's incisions at 10-2-6. Six pounds 14 oz.

Presented at the *106th Annual Session of the Medical Association of Georgia, May 3, 1960, Columbus, Georgia.

DUHRSSSEN'S INCISIONS / Graffagnino

infant. Uncomplicated p.p. course. Excellent cervical healing at six weeks.

Subsequent pregnancy four years later. Again induced for preeclampsia. Twelve hours labor, 45 minutes second stage, spontaneous delivery. Cervix intact.

5. L.T.: 28-year old colored para i. Previous prolonged labor and delivery 12 years before. Difficult forceps; neonatal death, (11 hours). Spontaneous onset labor at 39 weeks. Irregular pains 24 hours. Spontaneous rupture of membranes followed by seven hours good labor. With cervix at 7 cm., plus one, FHT's became markedly irregular, (40/min.). Moved immediately to delivery room. Midforceps application to ROT through cervix, Duhrssen's incisions 10-2. Delivery of six pound 9 oz. infant.; obvious distress, but responded well to suction and oxygen. Survived in excellent condition; p.p. course uneventful. Cervix well healed at six weeks.

6. W.G.: 19-year old white primigravida. Spontaneous onset labor at 40 weeks. After four hours good labor, cervix 8 cm., completely effaced, plus one. FHT's became very irregular, dropped to 20/min. Moved immediately to delivery room. Membranes ruptured artificially; midforceps application to LOT. Duhrssen's incisions at 10-2. Delivery of nine pounds 1 oz. infant. Responded well to suction and oxygen. P.p. course uneventful. Cervix well healed at seven weeks.

Subsequent delivery three years later. Spontaneous delivery eight pounds 8 oz. Ten hours labor. Intact cervix.

7. J.G.: 24-year old colored para 0 ab. i. Admitted at 39 weeks, preeclampsia. Three failed pitocin inductions. Onset spontaneous labor 12 hours after last induction attempt. Inertia. After 20 hours labor, and while receiving i.v. of distilled water

and cervilaxin, uterus went into a severe tetanic contraction, (last pitocin 40 hours before). FHT's slowed to 30/min. Moved to delivery room. Membranes ruptured artificially. Midforceps application to ROT. Duhrssen's incisions at 10-2. Delivery under general, six pounds 5 oz. infant. Responded well as aspiration O₂, Nalline. P.p. course uneventful. Cervix at six weeks showed laceration and failure of healing at site of 10 o'clock incision.

It will be seen that excellent maternal and fetal results were obtained in all of these cases. Three of the four cases having prolonged labors and dystocia, later delivered four times after short labors and with no complications from or damage to the previous cervical scars. In all three of the cases with severe fetal distress, it is felt that the immediate delivery utilizing cervical incisions was not only preferable to cesarean section, but actually may have been life saving for the infant, in that the delivery was accomplished with the minimal loss of time.

Summary

In summary, Duhrssen's incision properly employed remain a valuable obstetrical procedure. In addition to the other prerequisites for safe vaginal delivery, they require that the cervix be completely effaced, at least 6-7 cms. dilated, and that the head be at or below the level of the spines. When immediate delivery is desirable and the cervix not yet fully dilated, they may be indicated in the following type of case: (1) prolonged uterine inertia which has failed to respond to usual measures; (2) maternal exhaustion; (3) fetal distress and prolapse of the cord (if the cervical conditions are met), and (4) occasionally in the delivery of a cervix-trapped head in breech extraction.

Medical Arts Building

GEORGIA HEART ASSOCIATION MEETING IN SAVANNAH

TWO GEORGIANS WILL be among the five leaders in the field of cardiovascular disease who will speak at scientific sessions of the Georgia Heart Association's 12th annual meeting, which will be held September 9-10 at the Oglethorpe Hotel in Savannah.

The program topic for the sessions will be "Congestive Heart Failure." Speakers and their topics are as follows:

Dr. Elbert Tuttle, Emory University School of Medicine, "Renal and Electrolyte Disturbances of Heart Failure."

Dr. Ed Wood, Medical College of Georgia, Augusta, "Hemodynamic Abnormalities in Heart Failure."

Dr. Dwight C. McGoon, Surgical Section, Mayo Clinic, Rochester, Minn., "The Surgical Correction of Lesions Producing Heart Failure" and "Additional Advances in Cardiac Surgery."

Dr. Mary Allen Engle, Department of Pediatrics, Cornell Medical Center, New York, N. Y., "Congestive Heart Failure in Children" and "The Treatment of Congestive Heart Failure in Children."

Dr. Thomas W. Mattingly, director of medical education, Washington Hospital Center, Washington, D. C., "The Clinical Manifestations of Heart Failure" and "The Treatment of Congestive Heart Failure in Adults."

GEORGIA'S NEW LAW FOR HOSPITALIZING THE MENTALLY ILL

Henry G. Neal; William Rottersman, M.D., and John L. Moore, Jr., *Atlanta*

THE COMMITMENT OF a patient to a mental hospital is a major medical procedure. Both the certification of a patient as requiring hospitalization and the commitment of a patient to a mental institution are often extremely traumatic to the patient and other members of the family. Properly conducted, the commitment procedure will require the physician to use to the fullest his knowledge, skill, and tact. The same approach and attitude used in referring a patient for psychiatric consultation or care are also helpful in the commitment procedure. The patient should not feel he is being rejected or stigmatized. The guilt and anxiety of relatives can be somewhat allayed by explaining to the relatives the illness and patiently answering their questions.

Commitment procedures have been comprehensively revised by a major piece of legislation enacted this year by the legislature. Act. No. 618 of the 1960 General Assembly of Georgia provides a new and comprehensive chapter dealing with the hospitalization of the mentally ill. This Act represents, under conditions at this time, the most satisfactory combination of the two conflicting aims of legislation of this character: (1) the careful preservation of the rights of the patients and, (2) the best care and treatment of the patient at all stages according to medical opinion in the community.

A review of procedures for dealing with the mentally ill since the Middle Ages shows three basic periods. Until the middle of the 19th Century "lunatics" were institutionalized with a minimum of procedure and in the most informal fashion. Beginning around the year 1850, a great emphasis was placed on preserving the basic liberties of those suffering

from mental illness. As a result, the courtroom setting for mental patients became very similar to that seen in criminal trials. For the last two or three decades a third stage has developed. This stage demonstrates the concern of psychiatrists and others to prevent surrounding the ill patient with the same procedure afforded criminals. Such procedures frequently alarm and disturb the patient, thus adversely affecting his chances of successful treatment.

Act No. 618 emphasizes the medical aspects of commitment more than the law previously used for "committing the insane." The 1960 law states:

"'Mentally ill person' shall mean a person who is afflicted with a psychiatric disorder which substantially impairs his mental health; and because of such psychiatric disorder requires care, treatment, training or detention in the interest of the welfare of such person or the welfare of others of the community in which such person resides . . ."

This language should be compared with the language of Ga. Code Ann. §49-601:

"Insane persons, deaf and dumb persons when incapable of managing their estates, habitual drunkards, and persons imbecile from old age or other cause and incapable of managing their estates."

Act No. 618 substitutes the words "mentally ill person" for the words "insane person." Although this may appear to be a minor change, it places the emphasis on proper medical treatment. The Act preserves all of the procedures designed to prevent the improper hospitalization of a person not in need of hospitalization.

Voluntary Admissions

A totally new provision, and one which may become increasingly important, is contained in Section 4 of the Act. This provides for voluntary admissions of patients needing psychiatric treatment to public

Mr. Neal is Assistant Attorney General assigned to the Executive Department. Dr. Rottersman, Atlanta psychiatrist, is Chairman of the Governor's Advisory Committee on Mental Institutions. Mr. Moore is an Atlanta attorney and Secretary of the Governor's Advisory Committee on Mental Institutions.

and private psychiatric hospitals. If, after voluntarily going to the hospital, the patient or any one properly representing him requests his release, the superintendent of the hospital may release him. However, if the superintendent finds that it would be dangerous to the patient or others to release him, the superintendent may decline to do so, if he files within three days an application with the Court of Ordinary in the patient's home county. The superintendent may not commence court action to obtain an order requiring the voluntary patient to stay at the hospital against his will unless the voluntary patient first requests his discharge. Thus, a patient who is voluntarily admitted to the hospital will not suddenly find himself involuntarily hospitalized without a hearing.

It has been shown that mental illness, like other illnesses, can be best treated when the patient requests treatment and requests it early. The experience of the Department of Public Health has demonstrated that early intensive treatment is effective in preventing prolonged hospitalization in a great many cases. We know from the past statistics that a large number of those admitted to Milledgeville State Hospital never leave before death. It is hoped that Section 4 of the Act, providing for voluntary hospitalization, will be a widely used provision of the new law.

Act No. 618 not only applies to public hospitals operated by the State of Georgia and the United States and its many agencies, but also to ". . . any other hospital approved for the purpose of this Act by the State Board of Health . . ." The Health Department is presently drawing rules establishing the necessary standards for approval of private hospitals for the purposes of Act No. 618. Those hospitals approved for purposes of the Act by the State Board of Health will be able to obtain court orders requiring the patients to remain in the hospital until medical opinion shows they should be discharged. The facilities and standard of care of private hospitals, approved by the State Board of Health, will probably be superior to the facilities available at Milledgeville State Hospital. It is, therefore, the physician's duty to investigate the possibility of hospitalizing the patient in a private facility rather than at Milledgeville State Hospital or at a federal facility.

Legal Procedures

The legal procedures for involuntary hospitalization under Act No. 618 follow very closely procedures used in the present law. Act No. 618 calls for a sworn petition from any person stating that he believes another person is mentally ill and in need

of hospitalization. This application must be accompanied by a certificate from a physician stating that he has examined the patient and is of the opinion that the patient is mentally ill and should be hospitalized. The application and certificate are filed with the Court of Ordinary of the county in which the patient is found.

Upon receipt of the application, the Court of Ordinary enters an order for ten days written notice. The notice must be sent to the three nearest adult relatives of the patient residing in the State. The notice is also to be given to the patient or his attorney or guardian.

The ten days' notice may be waived in writing by any of the relatives but not by the patient. The notice may be waived on behalf of the patient only by his attorney or guardian.

Thereafter, the Court appoints an examining committee of two physicians and one attorney (the county attorney or an attorney appointed by him) who examines the patient and reports to the Court their findings. Subpoena powers are provided for obtaining witnesses to appear before the examining committee.

The examining committee examines the patient at his home or at any other suitable place not likely to have a harmful effect upon his health. If the committee's report to the Court is not unanimous in favor of hospitalization, the Court or Ordinary must dismiss the application and proceedings.

If the examining committee's unanimous report states that the patient is mentally ill and in need of hospitalization, then the Court enters an order requiring the patient to be hospitalized. If the hospitalization is to be other than at Milledgeville State Hospital, the attorney should present a certificate to the Ordinary prior to the order. This certificate must show that satisfactory arrangements have been made and that the hospital will accept the patient for involuntary hospitalization.

Provisions For Appeal

There are adequate provisions for appeal by any interested party to the Superior Court where the issues will be submitted to a jury. Notice of the appeal must be filed within four days of the order of hospitalization. Pending hearing and hospitalization, the Ordinary is given power, as he has under present law, to confine the patient for the protection of the patient or others. The new law urges the Ordinary to confine the patient in his home or another suitable facility and not in the jail, except in an emergency. At the time, suitable facilities for violent patients are very few, and, unfortunately, in many cases the jail must still be used. Attorneys and physicians in each community should take every

available step to avoid detention of mentally ill persons in a jail with criminals.

Act No. 618 provides adequate procedures for the release of patients who, in the opinion of the superintendent, no longer require hospitalization. In addition, the patient or his proper representative may obtain examinations every six months. If dissatisfied with the findings, they may bring the matter before the Court of Ordinary. The new Act also preserves full rights of hospitalized patients to communicate by mail with anyone and to receive visitors. These rights may be restricted only for medical reasons entered on the clinical records of the patient. At no time is the superintendent of a hospital authorized to interfere with the patient's rights to communicate by sealed mail with the Division of Mental Health of the State Department of Public Health, the superintendent of the hospital, and with the Court which ordered his hospitalization.

As medical treatment is improved, we should expect to see less emphasis on the need to protect society from "violent" persons, and more and more emphasis on the curability of mental illness. As this stage is reached patients will become less reluctant to be hospitalized and involuntary hospitalization procedures will diminish in importance and number. Then the proper emphasis can be laid where it should be, on the best possible care and treatment of the particular condition of the particular patient.

Act No. 618, which became effective on July 1, 1960, is only one procedure for hospitalizing men-

tally ill persons in Milledgeville State Hospital or federal agencies. The provisions of the present law (Ga. Code Ann., Chapter 49-6), were specifically retained by Act No. 618. Thus, the attorney and the Court of Ordinary have a choice as to which procedure to follow. It is to be hoped that physicians encourage the use of the new law. Its goals are the best possible care and treatment of patients compatible with the safety of the public and of the patient.

Conclusion

The new legislation dealing with the hospitalization of the mentally ill respects and helps to maintain the dignity of patients. Act No. 618, to a greater extent than was previously possible, permits procedures for hospitalizing the mentally ill to approach the general principles for hospitalizing the physically sick person.

Some psychiatrists believe that even our new laws require revising. For example, we do not have emergency commitment procedures whereby the acutely disturbed patient may be taken directly to a hospital where he may be detained until regular commitment proceedings can be instituted, if this becomes necessary.

Human behavior and its deviations are increasingly becoming a concern of physicians. Medicine and the law have many areas of mutual concern. Act No. 618 is an example of enlightened progress in the important field of medicine and the law.

*Suite 1220 Citizens and Southern National
Bank Building*

CHARLES W. CRAWFORD BUILDING DEDICATED

OPEN HOUSE AND DEDICATION of the Charles W. Crawford Building, new headquarters for the Atlanta District of the Food and Drug Administration, was held June 24.

Located at the corner of Cypress and Eighth Streets, N. E., the Atlanta office becomes the second of 17 field installations of the FDA to occupy quarters specifically designed and built for the conduct of their unique and complex functions.

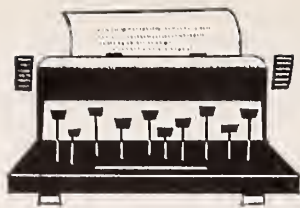
The Food and Drug Administration is one of the health agencies of the U. S. Department of Health, Education, and Welfare. It is a law enforcement agency charged with administering the Federal Food, Drug, and Cosmetic Act, and is headed by a Commissioner of Food and Drugs. The headquarters establishment in Washington, D. C., includes not only the administrative and management functions, but a complement of

research and testing laboratories as well.

The Food and Drug Administration has maintained offices and laboratories in Atlanta since 1934. Then, as now, its territory includes Florida, Georgia, South Carolina, and the western portion of North Carolina.



Architectural sketch of the building now occupied by the Atlanta District of the Food and Drug Administration, located at the corner of Cypress and Eighth Streets, N.E., Atlanta.



editorials

The Rising Incidence of Infectious Hepatitis

REVIEW OF EPIDEMIOLOGICAL evidence suggests that during the next few years, hepatitis will become an increasingly important disease problem in the United States.

It is perhaps surprising that knowledge of the cause and natural history of a disease as prevalent as viral hepatitis remained so limited until recently. Large epidemics of grave military significance during World War II gave impetus to the study of viral hepatitis and added important fundamental considerations to the basic understanding of the disease process and its etiology and control. While the hepatitis virus has so far never been isolated in the laboratory, currently available information warrants the view that two different and unrelated viruses are responsible for the occurrence of infectious hepatitis and serum hepatitis. The infectivity of both viruses seems to be limited to man, since attempts to infect other animal species have thus far proved unsuccessful. Infectious hepatitis occurs endemically and epidemically in most, if not all, areas of the world. It is spread by person to person contact and by contamination of food and water supplies. The incubation period usually varies between 14 and 40 days. The second form of viral hepatitis, serum hepatitis may not be readily differentiated in terms of clinical manifestations or pathologic anatomy from infectious hepatitis. In this form the virus is disseminated by means of blood or by materials or equipment contaminated with blood from individuals who are carriers of the virus. Serum hepatitis is, therefore, induced by the physician in carrying out necessary diagnostic and therapeutic procedures. It is charac-

terized by a remarkably long incubation period (30 to 160 days) and considerable resistance to heat sterilization.

For some reason, as yet unexplained fully, the incidence of infectious hepatitis has been observed to fluctuate in a cyclical pattern. This pattern appears to repeat itself in peaks occurring irregularly every five to ten years. Since hepatitis has been a reportable disease in the United States only since 1952, our experience in this country has been limited. Most of our background knowledge of these cycles has been obtained from Scandinavian and British reports where the disease has been reported for the past 30 years. These cycles seem to apply to reservoirs of population geographically isolated from one another in various parts of the world. Each individual area of the world appears to have its own cyclic timetable. So far international air transportation of large numbers of travelers seems to have had no detectable effect on the fundamental local incidence of the disease. There may be several reasons for this, but the chief seems to be that the younger age groups bear the brunt of the disease. This age group normally travels less and, therefore, fewer contacts are made. Also, since the incidence is highest among the lower economic groups, this factor provides some deterrent to its international spread. Some investigators have advanced the idea that when a new group of subjects reaches an age of maximum susceptibility a new rise in incidence occurs. This has neither been adequately confirmed nor denied. During this periodic fluctuation of morbidity from infectious hepatitis, the incidence of the

serum variety remains essentially unchanged. It is fairly well established that lifetime immunity to infectious hepatitis follows successful convalescence.

There are also definite seasonal trends in infectious hepatitis. It may occur in any month or season but there is usually an increase in the number of cases in early summer. Although fall and winter peaks of incidence are usual, summer epidemics of the disease are not uncommon. The last major hepatitis year in the United States, 1954, saw over 50,000 cases reported. The most recent national "low," less than 15,000 cases occurred in 1957. Beginning in 1958, annual morbidity has increased steadily. More than 23,000 cases have been provisionally reported in 1959 and future totals are expected to climb substantially higher.

Total cases reported from state health departments to the National Office of Vital Statistics since

January 1960 are more than 35 per cent above those for a comparable period in 1959. If present estimates are correct the incidence will have risen between 40 and 50 per cent by the end of the year. Hepatitis has occurred in all parts of the United States during the last few months but the greatest incidence has been observed in some states of the east south central area, and in portions of the northwest and southwest.

It is important that all doctors in Georgia remain vigilant for new cases with the goal of preventing any major local outbreaks. Each new case deserves careful reporting to the State Health Department. Until further progress is made in the isolation and cultivation of the virus, one must rely on intestinal isolation of the patient and treatment of the family and close contacts with gamma globulin.

Georgia Conference on Aging

OF PARTICULAR NOTE at the recent Georgia Conference on Aging was the emphasis placed on "community action" to meet the needs of Georgia's senior citizens. This two-day meeting was sponsored by the Governor's Commission on Aging held at Athens, Ga., June 30-July 1, 1960. Some 250 participants in this Conference drafted proposals for the Commission based on compiled reports from 82 County Committees on Aging and the Commission's subcommittees.

While the Conference considered total needs of the aged in the fields of housing, employment, income, recreation, education, etc., the health services group urged local aid and the use of existing facilities in meeting the needs of elderly persons.

The philosophy of the recommendation on medical and health services is best expressed in the summary statement of the Commission's Health Subcommittee as follows:

"It should be emphasized that the Subcommittee considers financial assistance programs necessary only for the 'needy aged' and the 'near-needy aged' persons. Furthermore, the Subcommittee believes

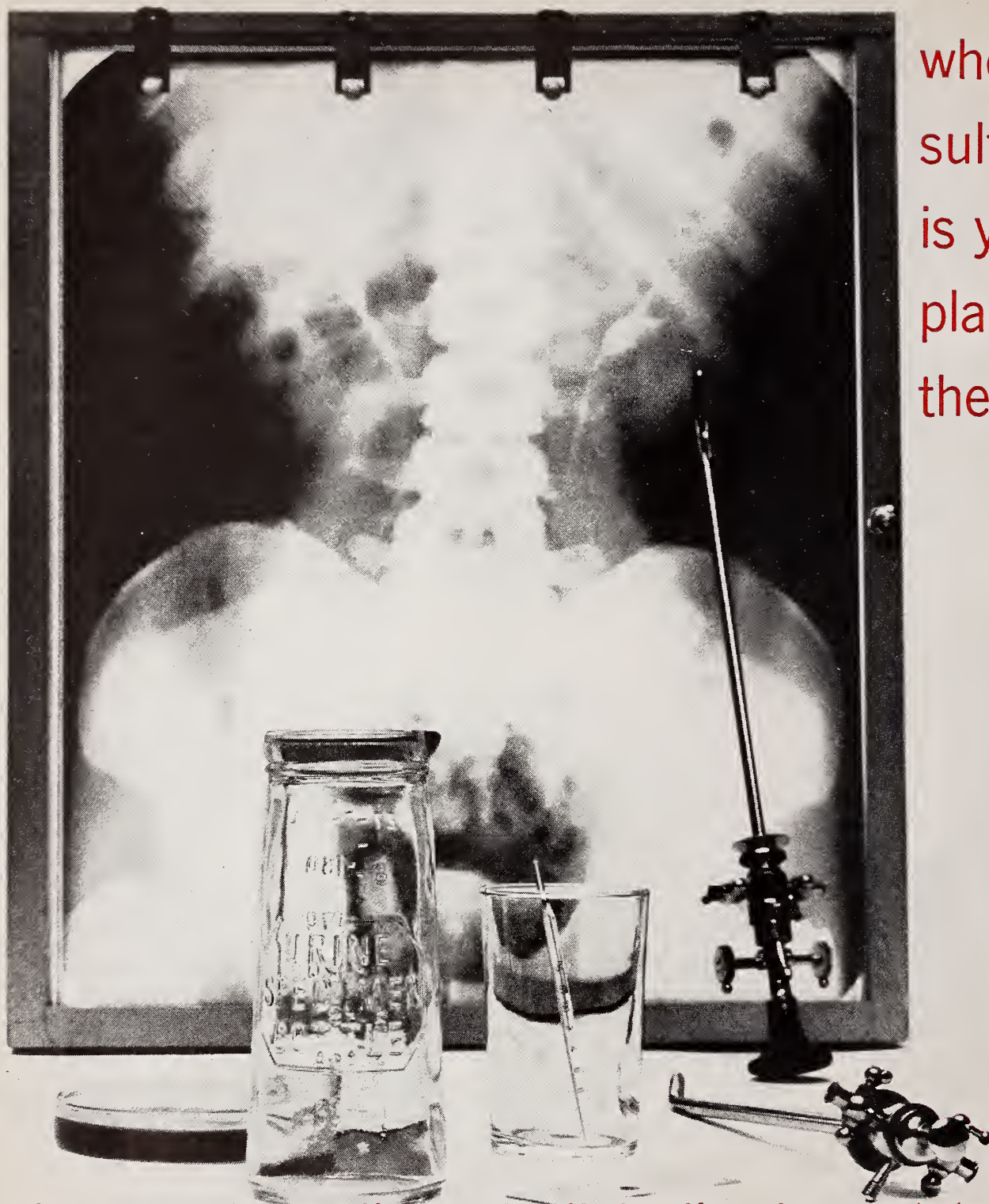
that such problems are best solved, first in the community; second, the county; third, the state, and only when such problems are insoluble on these 'grass roots' level do they address themselves to the federal government."

This philosophy was further stressed during the opening session of the Conference when Mr. Ed. L. Bridges, aide to Gov. Vandiver, stated, "Most of us seem to have the wrong attitude about older people. We are too prone to worry about taking care of them but doing nothing about it, instead of giving them a chance to take care of themselves."

The majority of Conference recommendations on health care will stimulate city or town, county and state aid to the needy and near-needy. These aims, in placing the responsibility of a society to its older persons at the community level are to be commended.

Georgia's first Conference on Aging has taken a giant stride in assessing the medical and health needs of senior citizens when they rightly seek solution of the problems of the aged "close to home."

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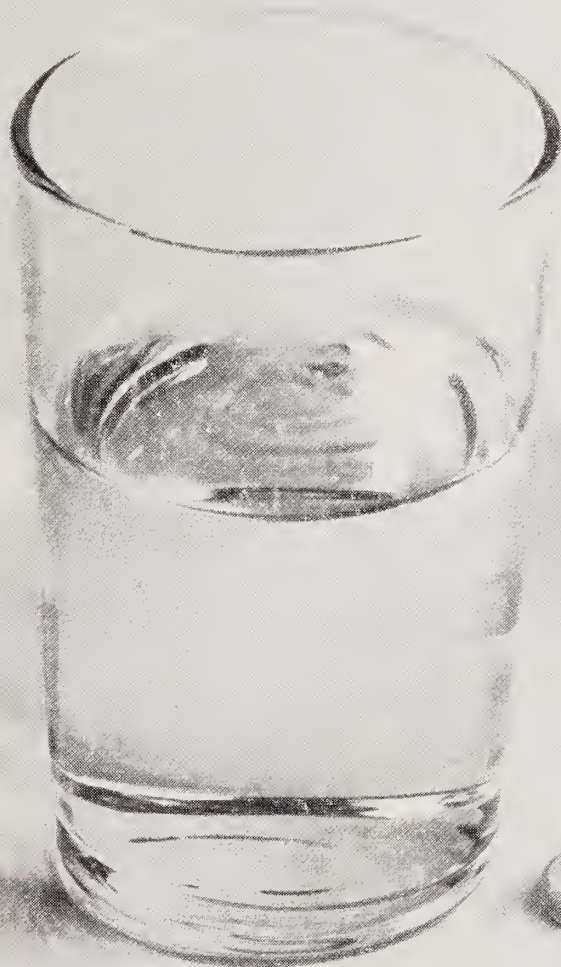
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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: *Antibiotic Med. & Clin. Ther.* 3:378, (Nov.) 1956. 2. Boger, W. P.: *Antibiotics Annual* 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: *Antibiotic Med. & Clin. Ther.* 5:604 (Oct.) 1958. 4. Vinnicombe, J.: *Ibid.* 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: *U. S. Armed Forces M. J.* 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: *Ann. New York Acad. Sc.* 60:457 (Oct.) 1957.

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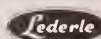
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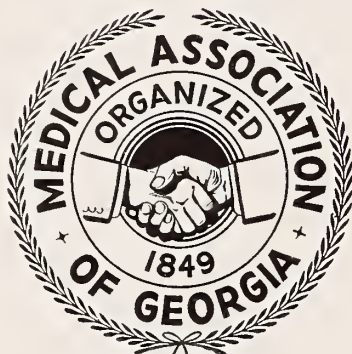
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1961 Annual Session

May 7-10, 1961—Atlanta Biltmore Hotel, Atlanta, Ga.



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All titles must be submitted to the respective
program chairmen listed below before
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CHEST

Joseph S. Cruise, M.D.
348 Peachtree Street, N.E., Atlanta 8
JAckson 3-7726

DERMATOLOGY

William L. Dobes, M.D.
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JAckson 1-2428

DIABETES

Ralph A. Murphy, Jr., M.D.
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TRinity 5-6407

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heart page

THE ROLE OF HEMATOLOGY IN OPEN HEART SURGERY

CHARLES C. CORLEY, JR., M.D., *Atlanta*

THE DEVELOPMENT OF SUCCESSFUL techniques of extracorporeal circulation has resulted in advances in cardiovascular surgery. Through the use of extracorporeal circulation, permitting by-pass of the heart and lungs, many cardiac defects can now be repaired with the heart open. The successful performance of such a procedure requires meticulous attention to details, many of which are hematological in nature.

The hematologic problems of open heart surgery using extracorporeal circulation fall chiefly into two categories: (1) the prevention and/or treatment of hemorrhagic disorders, and (2) the procurement and proper preparation of a sufficient amount of blood.

A variety of hemorrhagic disorders may be encountered in performing open heart surgery. One must consider certain hemostatic defects which (1) may exist in patients with cardiac disease, (2) may occur with the use of massive transfusions, (3) are peculiar to the use of extracorporeal circulation, and (4) may arise in any thoracic surgical procedure.

Patients with heart disease may, of course, have the coexistence of any coagulation disorder. There are, however, certain coagulation defects which are encountered with some frequency in patients who are candidates for heart surgery. Many patients with

cyanotic congenital heart disease have thrombocytopenia and hypofibrinogenemia. In addition, patients who have been in prolonged congestive heart failure are often found to have hypoprothrombinemia. Unless these abnormalities are corrected, or special preparations are made for handling them during surgery, such patients may bleed profusely.

Secondly, since large volumes of blood are necessary in extracorporeal circulation, the problems of massive transfusion must be considered. Blood stored by routine methods becomes deficient in platelets, antihemophilic globulin, labile factor, and, to some extent, prothrombin. Patients transfused with large volumes of bank blood develop deficiencies of factors missing from bank blood and may develop severe bleeding. For this reason it is essential to use fresh blood. Furthermore, platelets are destroyed by the trauma of being drawn into a vacuum and by contact with glass surface. It is necessary, then, to draw blood by the force of gravity and into either plastic or siliconized equipment. In addition, because of the hazard of citrate intoxication, it is necessary to use heparin rather than the usual ACD solution.

Other hemorrhagic disorders related to extracorporeal circulation may arise. A certain amount of trauma to the blood occurs during any procedure.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Prolonged plasma prothrombin times are frequently found, even after short procedures. In addition, a mild to moderate reduction of platelet count often occurs. After prolonged periods of cardiopulmonary by-pass, these deficiencies may be more severe and other defects may also occur. If any part of the apparatus is roughened or is not siliconized, or if the patient is not adequately heparinized, some coagulation may occur with resulting deficiency of all coagulation factors. Therefore, it is essential for any open heart operation to have the patient in the best possible hematologic status and to have available adequate volumes of fresh blood and special blood products for appropriate treatment of a variety of bleeding disorders.

One other hemorrhagic problem is encountered with special frequency in thoracic surgery and particularly with the addition of extracorporeal circulation. This is fibrinolysis. Mild fibrinolytic activity immediately after cardiopulmonary by-pass is seen frequently. On occasions it may be severe, and the administration of large amounts of concentrated fibrinogen and fresh whole blood may be lifesaving. Fortunately, fibrinolysis is generally of brief duration.

Probably the most common cause of bleeding immediately after by-pass is inadequate neutralization of heparin. As a general rule, the administration of protamine is a ratio of 2:1 to heparin initially given results in adequate neutralization of heparin. However, this does not invariably hold. If the platelet count is significantly reduced, more protamine will be necessary. Caution is necessary in the administration of additional protamine, since protamine in

high concentration is an anticoagulant. A protamine titration test is often indispensable.

With proper study and preparation of the patient before, during, and after surgery, serious bleeding is rare, provided meticulous attention has been given to surgical hemostasis.

In most cases the procurement and proper preparation of sufficient blood is the largest hematologic problem. Depending upon the defect and the size of the patient, from 12 to 20 pints of blood are needed. Between eight and 16 pints of blood are collected in a heparin solution for use during the period of cardiopulmonary by-pass. The rest of the blood is collected in ACD solution and is used during the pre- and post-by-pass periods of surgery and postoperatively. If coagulation disorders exist preoperatively, more blood may be needed for preparation of special blood fractions, such as platelet concentrates. All blood is collected into plastic bags on the morning of surgery.

The blood of each donor must be compatible with the patient at least as far as the ABO and major Rh types. To further assure compatibility, the blood of each donor should be cross-matched with the patient's blood by saline and Coomb's cross-match methods. In addition, it is recommended that all blood to be used in the extracorporeal circuit be inter-cross-matched. Generally, at least one month is necessary for these preparations. Prospective donors are seen initially at least a week prior to surgery for routine screening and compatibility testing.

With close cooperation of the thoracic surgeon, cardiologist, and hematologist, serious cardiac abnormalities can be successfully corrected. The secret to success is constant and meticulous attention to many details.

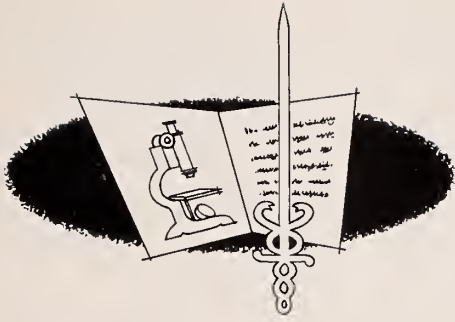
NURSING SCHOOL ADMISSIONS GAIN

ADMISSIONS TO SCHOOLS of professional and practical nursing reached an estimated 71,297 new students in 1959, compared with 68,851 in 1958, it was announced recently by Fred C. Foy, chairman, Committee on Careers, National League for Nursing, New York.

Professional nursing programs admitted 47,797 new students, a slight increase over the 47,351 admissions of the preceding year. Practical nursing schools enrolled an estimated 23,500 students in 1959, compared with 21,500 in 1958. Data are for the calendar year

and are gathered annually by the National League for Nursing through questionnaire surveys of professional and practical nursing schools.

Among professional nursing schools, diploma programs in hospital and independent schools continued in the academic year 1958-1959, as in previous years, to enroll the largest number of new students—37,686 or 81.4 per cent of the total. College programs offering a bachelors degree in nursing admitted 7,275 freshmen nursing students, or 15.7 per cent of the total.



cancer page

EXFOLIATIVE CYTOLOGY AND ITS APPLICATION

John T. Godwin, M.D., *Atlanta*

THE APPLICATION OF exfoliative cytology has been established as a major step in the early diagnosis of cancer. This applies primarily to the study of cervical and vaginal material. Up to the present time screening of other organs for carcinoma has not been practical. Cytological studies of bronchial washings and sputum have made possible the diagnosis of small and inaccessible cancers of the bronchi. Gastric and esophageal washings have been helpful in the differentiation of ulcerative lesions with a high degree of accuracy and offers great help in confirming a suspicious lesion prior to exploration.

Cytological studies may be performed on urine, prostatic secretions, colonic washings, duodenal aspirates, breast secretions, and pleural, peritoneal and cerebrospinal fluid. Cytological studies of material from these sites from time to time may be most helpful in clarifying a diagnostic problem. Such studies are best performed where the pathologist and clinician can freely consult. This is particularly true concerning the more common uterine cytological studies. The ideal situation is one in which the pathologist examines the cytological material, biopsy specimen, conization specimen, and the complete uterus in an individual case. This is not always practical but can be arranged in the majority of cases.

The proposed establishment of regional centers

for cytological studies as advocated by the "Cancer Cytology Foundation of America, Inc." is contrary to the best interests of the patient-clinician-pathologist relationship, which must exist for the best in patient care. This organization is not connected with the American Cancer Society and has received no support or encouragement from the American Cancer Society.

Most pathologists in the State will examine cytological specimens. However, if this service is not available, he will recommend a pathologist who will examine cytological material. A list of all pathologists in Georgia may be obtained from the Georgia Association of Pathologists or the Medical Association of Georgia.

The following information obtained in one cytological laboratory may be of some interest. In a review of 19,888 consecutive cases, in which cervico-vaginal cytological studies were performed, 196 were classified as Class III or above using the Papanicolaou classification. This gives an incidence of 0.9 per cent. Of this number, there were 131 cancers, giving an incidence of 66 per cent in smears Class III or above. Of the remaining 65, there were 12 in which follow-up studies are not complete. The remaining 53 revealed changes ranging from squamous metaplasia to atypical epithelial hyperplasia. There were six patients in whom cancers were sub-

Approved by Professional Education Committee, Georgia Division, ACS

sequently found in which the cytological studies had been negative on one occasion. Four in situ carcinomas were found where the cytological studies were originally reported as atypical with a request for repeat studies.

In this same laboratory, a study of biopsy, conization, and hysterectomy specimens has revealed interesting information. In a series of 248 patients in whom a diagnosis of in situ carcinoma was made, there were 176 who had a cervical biopsy followed by conization. In 18, the lesion was removed completely by the biopsy since no residual was found in the conization or hysterectomy specimen. Portions of the lesion remained in 127. The extent of the lesion was not determined in 31. Of these 31 cases in which the extent of the lesion was not determined by biopsy, the conization specimen revealed seven invasive carcinomas, 12 microinvasive carcinomas, and 12 in situ carcinomas.

An analysis of the 127 cases in which the lesion appeared in biopsy and conization specimens, 115 were in situ in both. Of significance in this series is that biopsy missed in situ carcinoma (including early stromal invasion) in 19 cases and invasive carcinoma in seven subsequently revealed by cold conization.

There were 132 cases in which a comparison was made between the diagnosis in the conization and hysterectomy specimens. There were 49 cases in which the lesions were identical. There were 77 in which the uterine lesion was less serious than the

cone. In 36 of 49, conization would not have eradicated the in situ lesion. In two cases with early stromal invasion, the same lesion appeared in the final specimen. In four cases of early invasion, a modified Wertheim procedure was performed and the lesion was the same as in the conization specimen.

The hysterectomy specimen of 131 patients diagnosed as in situ carcinoma in the conization specimen revealed eight with basal cell hyperplasia, seven with atypical epithelial hyperplasia, 36 with residual in situ carcinoma, three with early stromal invasion (microinvasion), and one with invasive carcinoma. Fifty-five or 42 per cent of the 131 cases with in situ carcinoma on conization revealed atypical in situ or invasive carcinoma in the hysterectomy specimen.

In summary, this information indicates that cytological examinations will be helpful in directing additional studies in about one per cent of patients. In this series, examination of tissues removed from additional studies indicates that multiple biopsies followed by conization and hysterectomy is the sequence of procedures in the usual case of a suspicious cytological specimen with an in situ lesion in the biopsy and cone specimens. Certainly this is not absolute, but is reasonably borne out in these studies.

Cytological screening of cervical and vaginal secretions is the best method we have for the early detection of cancer of the uterus and should be part of the annual or semi-annual examination of all women regardless of age.

PROGRESS IN PUBLIC HEALTH

PROGRESS IN CARRYING out the 1958 statewide restaurant sanitation law, beginning of a network of poison control information centers in hospitals, further development of intensive treatment centers for the mentally ill, and developments at Milledgeville State Hospital, highlighted the annual report of the Georgia Department of Public Health for 1959.

The report, released recently, showed that with the average life span greatly increased since 1900, there is a growing new emphasis on chronic illnesses and health problems of the aging.

This is the final annual report submitted by Dr. Thomas F. Sellers as director of the Department. Dr. Sellers, who is now director-emeritus, was succeeded by Dr. John Venable at the beginning of 1960. Dr. Sellers recounted a few of the changes in public health in his 42 years with the Department, the last 12 as

director. Among these are: eradication of malaria in 1938, scientific advances which made effective war on venereal disease possible, the keeping of vital records and statistics, the beginning of sanitary engineering for control of environmental sanitation, the development of public health dentistry, and the development of local health centers.

A budget of \$7,425,445 for the fiscal year 1959-60 made possible the public health services carried out in Georgia. In addition, the Department administered over \$8,604,000 in hospital construction funds, over \$4,210,000 for Battey State Hospital for tuberculosis, and \$1,508,000 for aiding crippled children. To this is added the \$10,700,000 budget of the Milledgeville State Hospital and the \$500,000 budget of the mental health intensive treatment program.



mental health page

SUICIDE

Robert J. Van de Wetering, M.D., *Atlanta*

THE IMPORTANCE OF suicide as a public health problem and as a matter of great concern to all physicians is indicated by the often neglected but alarming statistical evidence of suicide's prevalence as one of the leading causes of death in our country. Every year at least 16,000 and probably double that number of persons, successfully kill themselves. This rate is probably considerably higher, if the number of suicides which mask as accidents are taken into account. For each successful suicide there are at least five unsuccessful attempts. Thus, the cost of suicide in human suffering and human life is vast and should be of great importance to physicians everywhere.

The tragedy of these statistics is multiplied when one realizes that suicide is an eminently preventable disease. The physician, of course, does not bear the sole responsibility in prevention, but it should be his duty to educate and watch for the rather evident signs so that he may advise families and religious and social agencies in further preventive steps to take. It is most unfortunate but understandable that the myth has been promulgated that a person who is truly intent upon suicide never announces this fact. Probably this myth has been perpetuated to allay the guilt of families and friends who, if they took the suicide at his word, could have successfully taken steps to prevent the subsequent fatal action. The intended suicide often seems rational in many other or all other aspects of his behavior and cer-

tainly does not correspond to the picture of the "maniac" as portrayed on screen, stage, and printed page. The family is apt to wait to see if "John doesn't work himself out of this" with the frequently fatal results which follow.

It has been statistically proven that over 75 per cent of all successful suicides have previously announced their intentions by verbal threat, written note, or previous suicide attempt. Thus it becomes evident that any profession of a desire to die, or undue preoccupation with death, must be treated seriously and with appropriate action. I often hear the statement that "she tried before but I thought it was only a gesture." Even these so-called "gestures" are, however, evidence of a severely disturbed personality and one which in a child-like and most omnipotent way attempts to control the environment through threats of his own death. I am sure we can all remember when as children we had fantasies of our parents' sorrow and grief (as did Tom Sawyer), we made our parents suffer for a supposed wrong through our own death. "They'll be sorry when I'm dead." This relatively common and normal fantasy of childhood is often seen in adult life. So even the so-called dramatic gesture of the disturbed individual must be taken with some degree of seriousness since it, too, may get out of hand and cause death.

Suicide must be considered an illogical act. When one considers the tenacity with which most persons cling to life, and under the most desperate of cir-

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

MENTAL HEALTH PAGE / Continued

cumstances (such as German concentration camp survivors during the War), then the desire for self-destruction can be seen as eminently illogical and irrational.

Of prime importance in the prevention of suicide is the accurate diagnosis of depression. Depression is not difficult to diagnose but is frequently omitted or forgotten in the welter of secondary symptoms which depressed patients can often present. The following points are paramount in the diagnosis of depression, and since probably about half of all suicide attempts are carried out by individuals with depression, it must be realized that all depressives are potential suicides:

1. Insomnia, which is characteristically early morning awakening, with inability to go back to sleep.

2. Anorexia (and weight loss), with or without nausea and vomiting.

3. Loss of interest and drive, with cessation of

social activities.

4. Weakness, sometimes with apathy and retardation.

5. Despondency ("worried"—"I have everything to be thankful for but somehow nothing seems right.")

6. Feelings of worthlessness.

An agitated depression is one in which the above are present but are sometimes masked by an inability to sit still, a constant restlessness, pacing the floor, and wringing of the hands. This is often misunderstood to be anxiety and is treated by ataractics which often only serve to increase the depth of depression.

It is hoped that the physician will treat with consternation any suicidal threat or attempt or "gesture" and do his utmost to make the patient's family treat the act with a similar degree of concern. Psychiatric referral will often be helpful in deciding upon a means of disposition (e.g., hospital or out-patient) and an appropriate mode of treatment (e.g., psychotherapy, medicine, or electricity).

CONGRESS FACES HEALTH CARE ISSUE

CONGRESS RETURNED TO WORK this month to take up its unfinished business, including the controversial issue of health care for the aged, an atmosphere dominated by election-year politics.

The three or four week, tag-end session of Congress loomed as one of the most important meetings in the past decade, as far as possible impact on the medical profession is concerned.

The lawmakers are slated to decide whether to embark the Federal government on a course that could threaten the private practice of medicine, or to adopt a voluntary program that would pose no such danger.

The omnibus social security bill approved by the House Ways and Means Committee was easily cleared by the House, 381 to 23, and sent to the Senate Finance Committee, which held two days of hearings. The measure contained a voluntary, Federal-State program for assisting needy aged persons meet their health care costs. Both the Administration and the American Medical Association endorsed the House measure as in keeping with the concept of giving the states prime responsibility for helping their citizens, for aiding those who are most in need of help, and for avoiding the compulsory aspects of health plans involving the social security mechanism.

A vote by the Finance Committee, headed by Sen. Harry F. Byrd, (D., Va.), was scheduled shortly after the Senate resumed operations in August. Whatever

action the Committee took, however, proponents of schemes such as the Forand bill to provide a compulsory, federal medical program promised a determined fight on the floor of the Senate.

In the event Congress should approve a government medicine plan, opponents were counting on a President veto to kill the measure. The Chief Executive repeatedly has asserted in strong language his all-out opposition to any compulsory plan for health care financing.

At the Senate Finance Committee hearing, Arthur S. Flemming, Secretary of Health, Education, and Welfare, renewed the Administration's flat stand against the social security avenue to financing health costs. Such a plan, he said, would inevitably lead to pressures for expanding the benefits and lowering or eliminating the age requirement. Under such circumstances, a 15 per cent or 20 per cent social security payroll tax would not be too far off. He said, "We believe it is unsound to assume that revenue possibilities from a payroll tax are limitless."

Dr. Leonard W. Larson, President-elect of the American Medical Association, told the Committee the House bill is the "antithesis of the centralized, socialized, statist approach of the proposals advocating national compulsory health insurance."

"To those critics who call this program modest, we say that fiscal irresponsibility, unpredictable cost, and maximum nationalization are not the accepted criteria for good legislation," he testified.

current clinical concepts

Why "Man-Tan®" Tans

PATIENTS REPEATEDLY ask dermatologists about the use of cosmetics, "are they safe?" or "will they harm the skin?" The pseudo-secretiveness that surrounds a chemical formula often produces an "I don't know" answer from the doctor. Therefore, the following report by Dr. Murray Zimmerman of Whittier, California about "Man-Tan®" should be of interest to us all.

"The Consumers' Report had an article on "Man-Tan®" in the February issue, implying that "Man-Tan®" was causing numerous "severe allergic" cases of dermatitis. They very properly stated that "Man-Tan®" is actually dihydroxyacetone. Dihydroxyacetone is made by mixing glycerine (or glycerol, if you prefer) with a yeast, and with a friendly bacterium which chews off the middle hydrogens and leaves dihydroxyacetone behind. I don't see how this compound would be any more allergenic than glycerol or acetone, both of which are its most closely related chemical relatives. Since the yield of dihydroxyacetone from glycerine by this bacterial dehydrogenation is 100 per cent, the stuff must be dirt cheap to make. The Consumers' Report also said that "quinoid" chemicals are formed on the skin from dihydroxyacetone. This would indicate a dimer, when what actually happens is that dihydroxyacetone polymerizes to a trimer. The trimer is dark brown, and that is what makes the pigment on the skin. Of course this is a dye, Madison Avenue advertising mendacity notwithstanding.

I wouldn't argue for a minute that someone isn't going to have a contact dermatitis from "Man-Tan®," since I'm sure that there will be a protracted exposure of a goodly segment of the population to it. However, I certainly do not think it is nearly as harmful as electromagnetic radiation, which produces skin cancer in an absolutely quantitative response to the number of ergs of energy absorbed by a given square centimeter of hide. Since I have a

great many patients who will expose themselves to the sun in summer and winter to keep up a cosmetic tan, I would sooner see them using "Man-Tan®" with the off-chance of a contact dermatitis than continuing to expose themselves to electromagnetic radiation."

Zimmerman, Murray, M.D.: The Schoch Letter, Dallas, Texas.

Obesity

THESE EQUIVALENTS MAY be set up for a 190 lb., five feet 10 inch man as follows: swimming one-half hour, 342 calories equals two dry martinis. Dancing as outlined above, 400 calories equals one hamburger sandwich. Eighteen holes of golf, 950 calories equals a piece of apple pie, a piece of cheddar cheese, and two glasses of milk. Walking one and a half hours equals one chocolate malted milk. And so it goes.

Long, P. H.: The Fat is in the Fire, Medical Times 87:699, 1959.

Emergency Renal Surgery in the Newborn Infant

RENAL MASSES OCCUR with sufficient frequency to justify early exploration which offers no great surgical risk in the first few days of life, and may actually be a lifesaving procedure.

Porter, Arnold, M.D. and Landsteiner, Ernest K., M.D., N. England J. M. 263:1, 1960.

Infantile Nephrosis

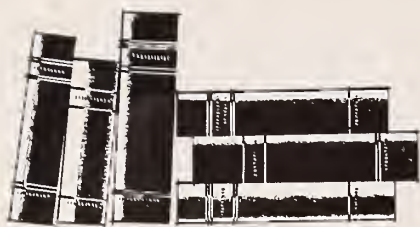
A WIDELY ACCEPTED theory regarding the etiology of human nephrosis proposes that the renal damage results from an auto immune process in which the patient produces antibody directed against his own kidneys. It seems unlikely that an immune reaction is the cause of nephrosis in the infant. These cases of infantile nephrosis with symptoms, physical findings, and laboratory abnormalities, although essentially the same as those of idiopathic childhood nephrosis, are characterized by a high familial incidence, refractoriness to treatment, and a high mortality rate.

Warthen, H. G.; Vernier, R. L., and Good, R. A: Infantile Nephrosis, JAMA Dis. Child. 98:731, 1959.

Changes in Renal Concentrating Ability Associated with Major Surgical Procedures

WHILE IMPAIRMENT OF the kidneys concentrating ability is usually transient and returns toward the preoperative values within 24 hours following surgery, there is marked decrease during the operative procedure despite the administration of exogenous vasopressin.

Gullick, Herbert D., and Raisz, Lawrence G., M.D., N. England J. M. 262:26, 1960.



physician's bookshelf

BOOKS RECEIVED

Riseman, Joseph E. F., M.D., P-Q-R-S-T, A GUIDE TO ELECTRO-CARDIOGRAM INTERPRETATION, The Macmillan Co., New York, N.Y., 1960, 168 pp., \$6.50.

Marti-Ibanez, Felix, M.D., CENTAUR, ESSAYS ON THE HISTORY OF MEDICAL IDEAS, MD Publications, Inc., New York, N.Y. 1958, 714 pp., \$6.00.

Williamson, Paul, M.D., OFFICE DIAGNOSIS, W. B. Saunders Co., Philadelphia, Pa., 1960, 470 pp., \$12.50.

Marshall, James, M.D., DISEASES OF THE SKIN, The Williams & Wilkins Co., Baltimore, Md., 1960, 944 pp., \$15.00.

Mulholland, John H., M.D.; Ellison, Edwin H., M.D., and Friesen, Stanley R., M.D., CURRENT SURGICAL MANAGEMENT II, W. B. Saunders Co., Philadelphia, Pa., 1960, 348 pp., \$8.00.

REVIEWS

Marti-Ibanez, Felix, M.D., SIGERIST ON THE HISTORY OF MEDICINE, MD Publications, Inc., New York, N.Y., 1960, 313 pp., \$6.75.

ALL THOSE WITH even the dimmest interest in medical history will remember Henry E. Sigerist as a scholar of infinite wisdom and charm. This anthology is a labor of love by an admiring colleague, Dr. Felix Marti-Ibanez, Chairman of the Department of the History of Medicine, New York Medical College. It is a dazzling display of the man's immense erudition and his ability to express it in clear and absorbing prose.

Twenty-seven essays have been assembled in four categories. *Section I On Medical History* shows clearly how Sigerist was always interested in the past only as a key to the present and the future. An account of the medical specialties from Babylonia to 20th Century America forced the conclusion that "the physician's position in society is never determined by the physician himself, but by the society he is serving." Another lecture deals with the development of society's attitude toward hygiene with some rather unflattering comparisons between the viewpoint of the Greeks and the early Christians toward personal cleanliness. Our knowledge of industrial and occupational diseases is broadly treated in another chapter. "The Historical Development of the Pathology and Therapy of Cancer" can be read by all with morbid fascination. "American Spas in Historical Perspective" is charming Americana while "Science and

History" is a long-headed appraisal of the importance of science to modern education.

Section II relates to ancient and medieval medicine; *Section III* to the Renaissance. The essays on medieval surgery are less meaty perhaps than those on Paracelsus, Harvey, Pare, and Boerhaave, particularly the latter's influence on American medicine. His tribute to Sir John Harrington, inventor of the water closet, is well-known and always good reading.

The final sections are much more personal. The most moving chapter is his farewell address to the Johns Hopkins Medical History Club in 1927, in which he describes the founding of the Institute of the History of Medicine by Dr. Welch in 1929 and his own appointment as director a few years later. "Living Under the Shadow" is a poignant account of his own fatal illness, contrasting sharply with a frothy tribute to American truffles and to some sane advice on writing and reading for physicians in other essays.

A vote of thanks goes to the editor for assembling these contributions in one comfortable volume. There is an index but no illustrations.

Thomas Findley, M.D.

Hurst, J. Willis, M.D., CARDIAC RESUSCITATION, Charles C. Thomas, Publisher, Springfield, Ill., 1960, 139 pp., \$5.50.

THIS COLLECTION OF lectures contains expertly authored chapters on the physiological background, the role and use of drugs, external pacemakers and defibrillators, techniques of emergency thoracotomy, manual pumping and artificial respiration, as well as the theological and legal implications of truly "heroic therapy." It is humbling to learn that the first successful human resuscitation by thoracotomy was performed in 1902. Statistics disclose that in hospitals, particularly in the operating room, the vast majority of cardiac arrests occur in a relatively small group of patients who can be singled out for simple cardiac monitoring, special attention to oxygenation, ventilation and stability of blood pressure, and careful advance preparation in case arrest does occur. An irrefutable argument is made that all surgeons, regardless of subspecialty, have a moral obligation to become adept at thoracotomy and pumping techniques and a reasonable case is made for the same requirement for all physicians. Attorney Bowden warns that the doctor may be legally culpable if he does not (should have been prepared to do so) or even if he does (resuscitate a decerebrate). The last chapter is particularly successful in helping the reader formulate in advance what he should do, if anything, in various situations. It is gratifying to learn that the

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

proponents of external resuscitation and the surgical enthusiasts generally agree on the course of action in specific instances. Two trained people and reasonably quick access to breathing and pacemaker apparatus are minimal requirements even in favorable cases.

Reviewers are supposed to react to minor irritants and this one responded briskly. Careless proof reading was the stimulus. One of the authors (Dr. Leighninger) is not identified in the list of contributors (page V) and his qualifications must forever remain a mystery except to family and friends. Several fascinating early reports are alluded to but not listed in the bibliography (chapter 4). Cardiac sometimes comes out "cardic" (twice on p. 29), ventricles as "vetricles" (p. 63), directly as "directly" (p. 76) and following as "fololowing" (p. 84).

The style is informal; the material is well presented, and cannot fail to interest any physician. The field is surveyed broadly but in sufficient depth in the important features. The aims of this book are highly practical and it succeeds as well as the printed page can. The convinced reader might like next to have a "dry run" on a laboratory animal or a fresh cadaver.

A. Calhoun Witham, M.D.

Marvin, H. M., M.D., YOUR HEART—A HANDBOOK FOR LAYMEN, Doubleday & Co., Inc., Garden City, N.Y., 1960, 334 pp.

THIS IS AN outstanding contribution by an expert in heart disease, presented in a readable and understandable manner for laymen. The book is a milestone in presenting accepted, as well as controversial information regarding causes and treatment of all types of heart disease. Such dilemmas as sodium restriction, low fat diets, use of tobacco, early ambulation, and anticoagulants which often plague the patient, due to conflicting advice from friends and physicians, is handled in a masterful fashion. Unnecessary restrictions of the cardiac, both as to diet and activity is deplored.

Sections are devoted to hypertension, obesity, congestive heart failure, effect of tobacco, effect of pregnancy, congenital heart disease, and the place of the electrocardiogram. One might take exception to the statement that the electrocardiogram will eliminate acute myocardial infarction in 95 to 98 per cent of instances. A chapter is devoted to the place of exercise tests using the electrocardiogram, and the author concludes that these are useful in only a small percentage of patients but are unnecessary in the majority. The evaluation would be profitable reading for any physician who uses them. While the book is directed to laymen, its authoritative analysis would be invaluable to the specialist as well as the general practitioner.

R. Bruce Logue, M.D.

Hunter, George W., III, Ph.D., Col. U.S.A. (Ret.); Frye, William W., Ph.D., M.D., Sc.D. (Hon.) and Swartzwelder, J. Clyde, Ph.D., A MANUAL OF TROPICAL MEDICINE, W. B. Saunders Co., Philadelphia, Pa., 1960, 892 pp.

THE FIRST EDITION of this well-known compendium was published during World War II primarily for use by the Armed Forces. Its popularity has been well deserved. More than 30 authorities have contributed succinct accounts of the most important bacterial, viral, rickettsial, mycotic, and nutritional diseases of the middle zones to this edition. New chapters have been added on the Echo viruses, the adenoviruses, and the toxicology of pesticides. Medically important arthro-

pods, mollusks, and animals receive separate consideration and a chapter on the physiological effects of a hot climate is considered.

An idea concerning the superiority of the various chapters to those in the current textbooks of medicine is conveyed by the fact that 27 pages are devoted to amebiasis, 45 to malaria, 13 to leprosy, four to kwashiorkor, and 23 to schistosomiasis. There are many charts and illustrations, the volume not being at all bulky, yet containing an immense amount of useful information.

Thomas Findley, M.D.

Hanlon, John J., M.S., M.D., M.P.H., PRINCIPLES OF PUBLIC HEALTH ADMINISTRATION, The C. V. Mosby Co., St. Louis, Mo., 1960, 714 pp., \$10.50.

WHILE THE TITLE and content of this third edition of a standard textbook are directed toward administration in public health, there are many sections which will be of great interest to the average practitioner.

The chapters on Addictive Diseases, Chronic Disease and Adult Health, Accidents—A Public Health Problem, Mental Health, Rehabilitation and Public Health, The Private Physician, and Medical Care all should prove of unusual and pertinent interest to those concerned over the emergent health problems of mid-20th Century.

It is to be hoped that there will be wide interest in the chapters on The Philosophy of Public Health and on The Background and Development of Public Health in the United States, both of which are not only factual presentations but also show deep insight into necessary relationships between public health and the practice of curative and preventive medicine. This is well illustrated by the statement that "In the final analysis the family physician should be the family health officer . . ."

The final chapter, The Future, is a masterful presentation of the demographic, the economic, and the social and political revolutions and their impacts on health and health care in the future. This should be thoughtfully read by all who offer or will consume such care in the next decade or two.

John H. Venable, M.D.

Leigh, M. Digby, M.D. and Belton, M. Kathleen, M.D., PEDIATRIC ANESTHESIOLOGY, The Macmillan Co., New York, N.Y., 1960, 461 pp., \$12.00.

ALTHOUGH THIS VOLUME is a revision of an early edition of the book by the same title, it might well be considered a brand new textbook. For those of us who are native Georgians, it is high-lighted by a frontispiece prepared by Mr. Joe Jackson of Emory University, which also served as the cover of the *Journal of the Medical Association of Georgia* for October 1959.

"Pediatric Anesthesiology" is divided into four sections. The first section deals with a brief description of the common childhood diseases, both bizarre and ordinary. Coupled with a discussion of these diseases is a suggestion of how to go about evaluating the patient for surgery and anesthesia.

The second portion of the book deals with anesthetic agents and techniques, and equipment satisfactory for use in pediatric anesthesia. To a major extent, techniques used on adults have been feasible for use on the very young by modifications in anesthetic equipment, primarily as regards size and resistance factors.

The third section of the book deals with preanesthetic medication and preoperative preparation of the

PHYSICIAN'S BOOKSHELF / Continued

pediatric patient. This is most interesting from the standpoint of the increasing use of tranquilizers, of rectal barbiturates and intramuscular preparations for rendering the patient unaware of the induction of anesthesia.

The book is then summarized in the fourth section, which is entitled "Anesthetic Management for Specific Surgical Procedures." In this section practically all surgical procedures are listed with various methods of management being described. The authors, of course, express their preference in these matters, and I think it can be well accepted that they are expert in the field.

Pediatric anesthesiology is rapidly becoming a subspecialty in our field. This book is highly recommended to anyone called upon to administer anesthesia to infants and children, and would certainly be of the most interest to surgeons who deal with pediatric patients and to pediatricians alike. It is a well prepared, easy to read, and well organized volume.

Lester Rumble, Jr., M.D.

Hall, Robert E., M.D., NINE MONTHS' READING, Doubleday & Co., Inc., Garden City, N.Y., 1960, 191 pp., \$2.95.

THIS BEAUTIFULLY WRITTEN book is a medical guide for pregnant women. Many obstetricians are hesitant about recommending books of this nature for their patients to read for several reasons. The instructions and methods of handling situations often differ between author and practicing obstetrician. In some books each paragraph closes with the admonition to call your physician if there is any question, so the doctor gets a multitude of calls and ends up answering all the questions anyway. Each physician must, of course, decide for himself whether a given book of this character fulfills his needs, but, in my opinion, there is much to recommend Dr. Hall's book.

The author is comprehensive covering physiology, symptoms and sensations, rules and regulations, complications, and both normal and abnormal labor and delivery. Also, there are two chapters on the often neglected puerperium. Dr. Hall has a very pleasing style that never sounds pedantic or platitudinous. The book should be both easily understood and reassuring to the expectant mother. The author creates the impression that there is more than one acceptable way to handle situations and problems. On controversial subjects, such as natural childbirth, the author tries to state honestly the pros and cons, but at the same time states his personal views. The chapter on rules and regulations is refreshingly up to date. In summary, to paraphrase some of the author's own words, the purpose of this book is to satisfy the healthy intellectual curiosity of the modern American woman and the author assumes that if she is hemorrhaging or hurting, she will consult the doctor and not the book.

Mark Pentecost, Jr., M.D.

Bakwin, Harry, M.D. and Bakwin, Ruth Morris, M.D., CLINICAL MANAGEMENT OF BEHAVIOR DISORDERS IN CHILDREN, W. B. Saunders Co., Philadelphia, Pa., 1960, 597 pp.

THIS COMPREHENSIVE BOOK presents its subject matter in a concise and understandable manner. In general, the

book is well organized, and this should make it particularly useful for students and as a quick reference for the management of some special problems of behavior disorders in children.

The book, as a whole, represents a coordinated approach to the problems by authors well qualified by experience.

Preston D. Ellington, M.D.

Welt, Louis G., M.D., CLINICAL DISORDERS OF HYDRATION AND ACID-BASE EQUILIBRIUM, Little, Brown & Company, Boston, Mass., 1959, 336 pp., \$7.00.

THE SECOND EDITION of this excellent book brings the subject up to date and adds a chapter on the special electrolyte and fluid problems of the pediatric patient. As those who are familiar with this book will recall, the material is divided into two parts. Part one includes the basic chemical and physiological considerations which are essential for any clinical understanding of the problems of body water and electrolytes. Included in this first part of the book is the excellent chapter on renal physiology. The material in this portion of the book is presented in a manner which lessens the burden of understanding this difficult material for those unfamiliar with the subject.

The second half of the book is given over to clinical considerations. The chapter discussing adrenal cortical insufficiency and diabetes insipidus is particularly well done. It might have been well to have included a chapter on the postoperative patient.

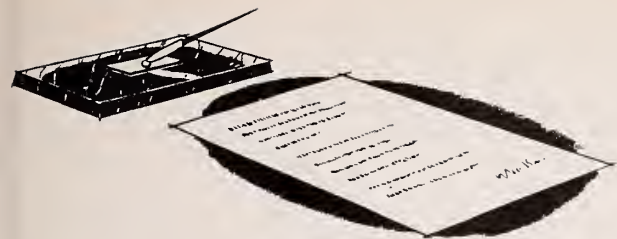
As there are many books written on this important phase of medicine, it should be said that this is one of the best from the standpoint of organization as well as content.

Charles L. Whisnant, Jr., M.D.

Top, Franklin H., M.D., M.P.H., F.A.C.P., COMMUNICABLE AND INFECTIOUS DISEASES, The C. V. Mosby Co., St. Louis, Mo., 1960, 812 pp., \$20.00.

AS IS THE CASE in most scientific areas these days, textbooks of medicine are increasingly forced to condense and omit information in order to provide space to present vast amounts of new material. Thus arises the need for sub-specialty textbooks, of which Dr. Top's newest edition becomes an excellent example. Written with the help of 21 collaborators, this is a textbook of Infectious Disease, presenting 55 chapters which cover almost every infectious disease of any importance. These chapters are brief, but well written and up-to-date. The first eight chapters are devoted to general principles of the host parasite relationship, antimicrobial therapy, and prevention of spread of disease. In general, these chapters are complete, accurate, but uninspired. The chapter on chemotherapeutic and antibiotic agents by Dr. Lepper, however, is superb. This is the best resume of the mechanism of and rationale for antimicrobial therapy this reviewer has encountered. Many valuable tables and charts are presented. The chief value of this book and its aim is to provide a reference for physicians encountering infectious disease. It may also serve to provide a rational basis for antibiotic therapy to physicians confused by this overgrown field.

Thomas F. Sellers, Jr. M.D.



Jackson, Gordon W., Medical College of Georgia, Augusta, Georgia, "Primary Carcinoma of an Artificial Vagina," Obst. and Gynec. 14:534-536, (Oct) 1959.

In May 1958, Mrs. L. B., a 25 year old, white female was referred to the Eugene Talmadge Memorial Hospital by Dr. A. W. Simpson, Jr. of Washington, Georgia, with a biopsy diagnosis of primary carcinoma of the vagina.

The patient's development had been normal until puberty, but menstruation failed to occur. At age 17, she was found to have absence of the vagina and right kidney. The left kidney was located ectopically in the pelvis. In 1950, at age 17, a vagina was constructed without employing a skin graft. She wore a vaginal mold until 1953 when it was necessary to revise the vaginal dome. Skin was taken from the lateral aspect of the left thigh and grafted in the dome of the vagina. Once again she wore the vaginal mold until she had the second reconstruction of the vagina without skin grafting in 1955. She married shortly thereafter and it was not necessary to wear the mold. She did well until some three months before admission, when she developed a blood tinged vaginal discharge. Pertinent physical findings were normal external genitalia, vagina some seven cm. in depth and a four cm. raised exophytic lesion on the posterior wall extending to the vault. Rectal examination disclosed an induration of the rectovaginal septum extending to the right pelvic wall. After much discussion, it was considered, in view of the additional difficulties presented by the congenital anomalies, that surgery would be hazardous. She was treated with radiation and did well for three months when a recurrence in the dome was noted. Extensive surgery was planned. The patient returned to her home in Louisiana where an exploratory was done and the disease was found to be too extensive for surgery.

Only one other primary carcinoma of the vagina in a patient having congenital absence of the vagina has been reported. In 1929, Ritchie reported its occurrence in a patient who had had a vagina made from a loop of small bowel. It was an adenocarcinoma and appeared to be a primary carcinoma of the bowel.

In the case here reported the question is whether the carcinoma arose in the skin graft or in the skin that

granulated in. If it arose from the skin graft, would it have arisen had the skin not been grafted. Also, what was the effect of the continuous wearing of the vaginal mold. Unfortunately, these are unanswered questions.

Murphy, Gerald M., University of Nebraska; Wilmer, J. Grant, and Claiborne, T. S., 384 Peachtree Street, N.E., Atlanta 8, Georgia, "Transient Complete Heart Block Occurring during Nasal Irrigation," Circulation 21:543-545, (April) 1960.

A case is presented of a patient who developed complete heart block with unconsciousness during irrigation of the sphenoid sinuses with a high pressure spray of isotonic saline solution. Following this period of insufficient circulation, the patient developed myocardial and cerebral damage but eventually made a normal and complete recovery. It was felt that the cause of this arrhythmia was a trigeminal vagal reflex in which sensory fibers of the trigeminal nerve were stimulated by the spray after reaching the brain through the trigeminal fibers the reflex impulse travels to the atrium through the afferent fibers of the vagus inhibiting the SA node, the AV node and the entire atrium. After a brief period of cardiac standstill an idioventricular rhythm commenced unfortunately at a rate too slow to allow a normal blood flow. The trigeminal vagal reflex from the eyes and nose and the similar vagal reflex from the pharynx, esophagus, trachea, etcetera, are important causes of cardiac arrhythmia and arrest during various sorts of manipulations in surgery in this area. The use of atropine is helpful in minimizing such occurrences.

Hock, Charles W., 1467 Harper Street, Augusta, Georgia, "Medical Management of the Normal, but 'Unwell' Patient," South. M.J. 53:638-642, (May) 1960.

Approximately 70 to 80 per cent of all patients in most physician's offices are functional patients. This group of patients is frequently misunderstood and spoken of in derision. The "Organic School of Medicine" believed that there should be visible evidence of disease, either by sight or test, for disease to be present. Today it has been proven that abnormal physiologic processes may cause as much as more symptoms as organic disease.

Organic disease must be reasonably

excluded; a diagnosis of functional disease can only be made by exclusion through thorough histories, complete physical examinations, and indicated laboratory procedures. The "complete" or "total" patient must be considered and not one segment of the anatomy.

Adequate explanation must be made to these patients as to why and how they get discomfort. Only by a thorough understanding of the condition and by team-work effort of doctor and patient can improvement result.

Many forms of treatment are necessary and are *individualized* for the patient. One new product, nandrolone phenpropionate (Durabolin®, Organon Inc.), was used intramuscularly on 25 functional cases with helpful results.

Ambrose, Samuel S., M.D. and Swanson, Homer S., M.D., 1938 Peachtree Road, N.E., Atlanta 9, Georgia, "The Hypertonic Neurogenic Bladder in Children: Its Sequelae and Management," J. Urol. 83:672-678, (May) 1960.

Thirteen children with hypertonic neurogenic bladders causing chronic urinary infection and urinary incontinence were considered in this paper. The primary spinal cord lesion was meningo-myelocele in six, intraspinal lipomas involving the conus in three, cord trauma in two, and in two unknown.

Uninhibited hyperreflexia of the bladder producing frequent, unsustained contractions of the detrusor with resulting hypertrophy and trabeculation of the detrusor was noted in all. Determination of residual urine, bladder capacity, cystoscopic examination, cystograms, pyelograms, and cystometry were performed in each patient in the course of urological evaluation.

Three patients had bilateral hydro-nephrosis and hydroureters resulting from lower tract involvement.

Incontinence resulted from uninhibited, involuntary contractions of the bladder and did not result from a relaxed sphincter. Treatment of incontinence of this type is directed toward elimination of these contractions by the use of anticholinergic medication, and if this is not successful, interruption of the spinal reflex is.

Three of these children obtained good results from anticholinergic medication alone. After satisfactory transient response to sacral nerve block with procaine was demonstrated, ten were subjected to sacral rhizotomy

ABSTRACTS / Continued

with satisfactory improvement obtained in eight. Five of these eight are free of incontinence and infection and three have mild stress incontinence.

Witherington, Roy and Caffery, Eldon L., Medical College of Georgia, Augusta, Georgia, "Permanent Perineal Urethrostomy," J. Urol. 83:682-685, (May) 1960.

In uncomplicated anterior urethral stricture, urethroplasty has excellent chance for success, particularly with good postoperative care. However,

many anterior urethral strictures are complicated by fistulae, urethral calculi, and abscesses and frequently these are not suitable for reconstructive operations. One method of handling these complicated strictures, particularly in the elderly man, is permanent perineal urethrostomy. Urethroplasty with maintenance of continuity of the urethra is generally preferable to permanent perineal urethrostomy but occasionally the latter procedure is indicated.

To perform perineal urethrostomy regional or general anesthesia is used. A metal sound is inserted into the

urethra. A vertical incision is made in the perineum from the posterior aspect of the scrotum to a point approximately one inch anterior to the anus extending the incision into the lumen of the urethra. A wedge of subcutaneous fat is excised on each side and posteriorly to permit the skin and urethra to be brought together without tension. The urethra is then divided at the distal end of the incision and the urethra and skin are approximated in a circumferential manner with catgut.

Postoperative follow-up is desirable and revision of the urethrostomy may be necessary in some cases.

CALENDAR OF MEETINGS

State

May 7-10, 1961—Annual Session, Medical Association of Georgia, Atlanta.

Sept. 9-10—Twelfth Annual Meeting, Georgia Heart Association, General Oglethorpe Hotel, Savannah.

Sept. 29-Oct. 1—Georgia TB Association and Georgia Trudeau Society, DeSoto Hotel, Savannah.

Oct. 12-13—Annual Meeting, Georgia Academy of General Practice, Dinkler Plaza, Atlanta.

Nov. 29-Dec. 1—"Fractures in General Practice," Medical College of Georgia, Augusta.

Dec. 6-8—"Workshop on Diabetes," Medical College of Georgia, Augusta.

Jan. 24-26—"Problems of the Newborn Infant," Medical College of Georgia, Augusta.

Feb. 19-22—Atlanta Graduate Assembly, Biltmore Hotel, Atlanta.

Feb. 28-Mar. 2—"Management of Your Patient with Vascular Disease," Medical College of Georgia, Augusta.

Regional

Sept. 14-16—Southern Trudeau Society and Southern Tuberculosis Conference, Hotel Francis Marion, Charleston, South Carolina.

Sept. 18-20—Medical Progress Assembly, Dinkler-Tutwiler Hotel, Birmingham, Alabama.

Sept. 26-27—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tennessee.

Oct. 12-23—Postgraduate Medical Seminar Cruise in Caribbean sponsored by the University of Florida College of Medicine, Gainesville, Florida.

Oct. 31-Nov. 3—Southern Medical Association, St. Louis, Missouri.

Oct. 31-Nov. 3—Interstate Postgraduate Medical Association, 45th Scientific Assembly, Pittsburgh Hilton Hotel, Pittsburgh, Pennsylvania.

Dec. 6-8—Southern Surgical Association, Boca Raton Hotel, Boca Raton, Florida.

Jan. 16-18—Sectional Meeting, American College of Surgeons, Hotel Dinkler-Tutwiler, Birmingham, Alabama.

National

Nov. 28-Dec. 2—American Medical Association, Clinical Meeting, Washington, D. C.

Sept. 1-3—Postgraduate Course in Clinical and Research Advances in Pediatrics, The Stanley Hotel, Estes Park, Colorado.

Sept. 1-6—Postgraduate Course in Pediatrics, The Stanley Hotel, Estes Park, Colorado.

Sept. 13-15—National Cancer Conference, American Cancer Society, Inc., and the National Cancer Institute, Minneapolis, Minnesota.

Sept. 24-27—College of American Pathologists, Palmer House, Chicago, Illinois.

Sept. 24-Oct. 2—American Society of Clinical Pathologists, Palmer House, Chicago, Illinois.

Oct. 2-7—American Society of Anesthesiologists, Inc., Statler-Hilton Hotel, New York, New York.

Oct. 5-8—American Academy for Cerebral Palsy, Penn-Sheraton Hotel, Pittsburgh, Pennsylvania.

Oct. 8—Sixth Annual meeting, American Rhinologic Society, Belmont Hotel, Chicago, Illinois.

Oct. 9-14—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Illinois.

Oct. 10-12—Congress on Industrial Health, Hotel Charlotte, Charlotte, North Carolina.

Oct. 10-14—American College of Surgeons, Clinical Congress, San Francisco, California.

Oct. 17-20—American Academy of Pediatrics, Palmer House, Chicago, Illinois.

Oct. 18—American Association of Poison Control Centers, Palmer House, Chicago, Illinois.

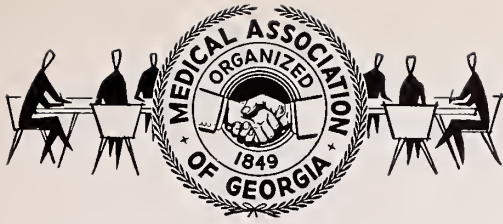
Oct. 21-25—American Heart Association, Inc., Jefferson Hotel, St. Louis, Missouri.

Oct. 31-Nov. 4—American Public Health Association, San Francisco, California.

Nov. 3-5—Postgraduate Course in Fractures, The Stanley Hotel, Estes Park, Colorado.

Dec. 4-9—Radiological Society of North America, Netherland Hilton Hotel, Cincinnati, Ohio.

Jan. 9-14—Postgraduate Course in General Practice Review, University of Colorado Medical Center, Denver, Colorado.



the association

DEATHS

JOHN H. HINES, 51, of Roswell died May 28 at a hospital in Atlanta.

Dr. Hines had practiced medicine in Roswell since 1950 and was associated with Dr. James F. Langford at the Hines Clinic in Roswell.

Born in Atlanta, Dr. Hines was a graduate of Marist College, Georgia Tech, and Emory University. He did postgraduate work at Vanderbilt University, and interned a year at both Grady Memorial Hospital and St. Joseph's Infirmary, Atlanta.

Following his medical studies and internship, he went to Canton, Mississippi, where he was with the Public Health services for four years. He then returned to Atlanta, where he practiced until moving to Roswell.

Dr. Hines was a member of the Fulton County Medical Association, Fifth District Medical Society, American Academy of General Practice, and the Southern Medical Association.

He was also a member of the Sacred Heart Church in Atlanta, the Druid Hills Golf Club, the Cherokee Town and Country Club, the Ansley Park Golf Club, Buckhead Elks Club, and the Allatoona Yacht Club.

Survivors include his wife, the former Josie Barnhill of McRae; a son, John David Hines, Roswell; his mother, Mrs. Cecelia L. Hines, Atlanta, and a sister, Mrs. Josephine Hines Upshaw, Houston, Tex.

JAMES BENJAMIN KAY, of Byron, who was 70, died June 25, at his residence after an illness of several months.

A native of Lowndesville, S. C., Dr. Kay was graduated from Emory University School of Medicine with highest honors and began his general practice in Byron following postgraduate training.

He founded the first obstetric hospital of its kind in Georgia and served the people of Middle Georgia for 35 years before retiring from active practice in 1956.

Prominent in medical circles, Dr. Kay served as president of the Bibb County Medical Society and president of the Georgia Academy of General Practice.

He was honored by the entire state in 1954 when he was elected Georgia's "General Practitioner of the Year." In November of the same year, he was honored by his own community when Byron observed "Dr. Kay Day."

Long active in church and community work in addition to his medical practice, Dr. Kay was a steward in the Byron Methodist Church and for many years was active in Boy Scout work. The scouts bestowed upon him their highest honor, that of the Silver Beaver.

Survivors include his wife, the former Miss Lena Adair of Clinton, S. C.; four daughters, Mrs. Edgar L. Duke, Jr., Ft. Valley, Mrs. William E. Pelham and Mrs. Richard J. Allen, both of Montgomery, Ala., and Mrs. G. L. Daniel, Jr., Orlando, Fla.; two sons, Dr. James B. Kay, Jr., Augusta and Dr. F. V. Kay, Macon; four sisters, Mrs. W. M. Speer, Atlanta, Mrs. Henry Moseley, Anderson, S. C., Mrs. T. H. Holcombe, Winston-Salem, N. C., and Mrs. Sam Hutchins, Greer, S. C., and 22 grandchildren.

WILLIAM DANIEL MIXSON, Waycross, died at his residence at the age of 90, June 2.

A native of Alabama, Dr. Mixson attended Malatien Seminary and was graduated from the medical school at Chattanooga, Tenn. His postgraduate work was done at the Tulane Medical School in New Orleans, the New York Ear, Nose, and Throat Clinic, and the Manhattan Ear, Nose, and Throat Hospital.

Having practiced medicine for over 50 years, he began his practice in Haw Ridge, Ala. and also practiced in Midland City, Ala., before coming to Waycross in 1919.

Dr. Mixson was a past president of the Ware County Medical Society, a member of the Eighth District Medical Society, the Medical Association of Georgia, the American Medical Association, the Southern Medical Association, and was on the staff of the former Kings Daughters Hospital and the Ware County Hospital.

He was a veteran of World War I, served as president of the First Federal Savings and Loan Association for 15 years, and was a member of the First Methodist Church.

Survivors include his wife, the former Pearl L. Fuller of Haw Ridge, Ala. and two sisters, Mrs. Walter E. Gibson, Dover, Fla. and Mrs. Bertie Hutchison, Montgomery, Ala.

WILLIAM ASBERRY SEWELL, 82, retired Floyd County physician, died in a Rome hospital June 22, following an extended illness.

Dr. Sewell was a graduate of the University of Ala-

bama and during World War I, served as a captain in the U. S. Army Medical Corps.

Coming to Rome in 1929 from Centre, Ala., Dr. Sewell served Floyd County and more particularly the Celanese Mill and village as resident physician, until 1947 when he retired.

He was a life member and past president of the Floyd County Medical Society, a member of the First Baptist Church, Cherokee Lodge 66 F & AM, the Shrine Zamora Temple in Montgomery, Ala., a charter member and past president of the Rome Lions Club, a director of the American Life Insurance Co., and a member and past commander of the Shanklin-Attaway Post 5 of the American Legion.

Survivors include his wife, the former Rose Fisch; three sons, David Sewell, Rome, William Sewell, Miami, Fla., and Preston Sewell, Atlanta; one daughter, Mrs. Ralph J. Davis, Rome; two brothers, Tom Sewell, Gadsden, Ala. and Crawford Sewell, Leesburg, Ala.; two sisters, Mrs. Charlie Bates, Ft. Payne, Ala. and Mrs. Sam Burns, Carrollton, and three grandchildren.

DAVID MARION SILVER, 70, Richmond County physician and coroner's physician for more than 12 years, died June 14 at a local infirmary after a brief illness.

Having lived in Augusta all of his life, Dr. Silver was graduated from the Medical College of Georgia, Augusta.

Dr. Silver retired from private practice a few months ago, but continued his work with the county.

Survivors include his wife; one daughter, Mrs. William P. Peyser, San Francisco, Calif.; three sisters, Mrs. Harry Kuhr, Augusta, Mrs. Edwin Adler and Mrs. Morris R. Adler, both of Atlanta, and two grandchildren.

SOCIETIES

The regular monthly meeting of the BIBB COUNTY MEDICAL SOCIETY was held recently at Pinebrook Inn, with J. Harold Harrison, Atlanta, presenting the program on the surgical treatment of cerebral ischemia due to occlusion of the carotid vertebral arteries.

Charles B. Watkins of Ellijay, entertained the members and wives of the BLUE RIDGE MEDICAL SOCIETY with a buffet luncheon at his home recently.

The FULTON COUNTY MEDICAL SOCIETY recently sponsored a free medical forum for the public on Respiratory Diseases at the Academy of Medicine in Atlanta.

Increased polio in Chatham County sparked a mass Salk vaccine drive which began the last of June. Backing the drive are the Savannah Pharmaceutical Associa-

tion and the GEORGIA MEDICAL SOCIETY.

Representatives from the Hall County Dental Association and the HALL COUNTY MEDICAL SOCIETY attended a recent city commission meeting in support of continued fluoridation of the Gainesville water system.

At a recent meeting of the NEWTON-ROCKDALE MEDICAL SOCIETY held at the Newton County Hospital, a resolution was passed urging the ambulance drivers to use more caution in answering calls in and near Covington.

TROUP COUNTY MEDICAL SOCIETY met recently at the Highland Country Club with Maj. Gen. Hugh Pate Harris, commanding general of the U. S. Army Infantry Center at Ft. Benning speaking. Members of the Troup County Dental Association and their wives were guests.

The scientific address at a recent meeting of the WARE COUNTY MEDICAL SOCIETY was given by a well known psychiatrist, Ed Adams Daneman, who discussed "Psychosomatic Disease, Hypochondriasis, and Somatic Delusions." Hosts for the meeting were W. L. Flesch, W. A. Hendry, and Katherine Hendry.

PERSONALS

First District

DR. and MRS. OSCAR H. LOTT, DR. and MRS. HENRY C. FRECH, DR. and MRS. EMANUEL F. ROSEN, and DR. and MRS. JACOB RUBIN, all of Savannah, recently attended the 25-year reunion of the graduates of the Medical College of Georgia.

H. WILDER SMITH, Swainsboro, has been certified for re-election to the American Academy of General Practice for the years 1960-62.

Having served the people of Savannah since 1910, ST. JULIAN R. DE CARADEUC has retired from active practice and is now making his home in Essex Falls, N. J., with his daughter.

Second District

WARREN A. TAYLOR, of Thomasville, has been elected vice chairman of the American Red Cross South Atlantic Regional Blood Program.

J. T. WRIGHT, Thomasville, has announced the re-opening of his office for the practice of general medicine.

At a recent meeting of the Pilot Club, MARGARET W. JOHNSON, Moultrie, spoke on pathology.

Third District

FRED E. SIMS, Dawson, has given up the practice of general medicine and with his family has moved to Charleston to attend the Medical College of South Carolina, where he will specialize in anesthesiology.

DR. and MRS. ROY L. GIBSON, of Columbus, recently attended the 25-year reunion of the graduates of the Class of 1935 from the Medical College of Georgia in Augusta.

The guest speaker at the first annual convention of

the Georgia State Association of Medical Assistants, held in Columbus, was LUTHER H. WOLFF, Columbus. A. B. CONGER and LEON LAPIDES, also of Columbus, participated in a panel discussion on "Lay Terms vs Medical Terms," during this meeting.

W. P. DURHAM, of Abbeville, formerly of Sasser, was recently honored by his community in "Appreciation Day."

ROY L. GIBSON, of Columbus, who recently stepped down as chief of staff at the Medical Center, presented graduation certificates to 14 doctors in ceremonies at the local hospital. HARRY H. BRILL, JR., also of Columbus, is the new hospital chief of staff.

Schley County citizens recently honored L. S. BOYETTE, Ellaville, in the observance of "Dr. L. S. Boyette Day."

Fourth District

No news submitted.

Fifth District

R. BRUCE LOGUE, Atlanta, recently attended the annual meeting of the South Carolina Medical Association at Myrtle Beach, S. C. and participated in two panel discussions.

NORTON FRIERSON, JR., Atlanta, and DR. and MRS. JOHN T. LESLIE, Decatur, recently attended a reunion of the graduates of the Class of 1935 from the Medical College of Georgia, Augusta.

J. FRANK WALKER, JOSEPH H. HILSMAN, LESTER RUMBLE, JR., ALBERT A. RAYLE, JR., G. LESTER FORBES, JR., and WALTER S. DUNBAR, all of Atlanta, recently participated in panel discussions at a meeting of The Fulton County Medical Society.

During the commencement exercises at Emory University, THOMAS F. SELLERS, Atlanta, received an honorary Doctor of Science degree.

At a recent public forum on Respiratory Diseases and Tuberculosis held at the Academy of Medicine in Atlanta, WILLIAM A. HOPKINS and JAMES F. HACKNEY, of Atlanta discussed various phases of the subject.

WOOD LOVELL, RICHARD E. KING, and LOUI G. BAYNE, Atlanta, have announced the association of Fred L. Allman, Jr. and the formation of the Atlanta Orthopaedic Clinic.

Sixth District

HERBERT M. OLNICK and GEORGE W. HALL, Macon, have announced an association for the practice of radiology.

DR. and MRS. MILFORD B. HATCHER, DR. and MRS. WILLIAM L. BARTON, and DR. and MRS. ROBERT W. McALLISTER, of Macon, attended the 25-year reunion of the Class of 1935 at the Medical College of Georgia, Augusta, recently.

BRASWELL E. COLLINS, Macon, has been advised by the American Board of Ophthalmology of his certification in ophthalmology.

WILLIAM R. NEWTON, of Macon, left recently for Augusta, where he will enter the Medical College of Georgia for a residency in pediatrics.

WILLIAM C. SHIRLEY and RICHARD L. HANBERRY, JR., Macon, have recently been certified by the American Board of Obstetrics and Gynecology.

LEO A. ERBELE, Macon, has recently been certified by the American Board of Clinical Pathology.

Seventh District

CARL C. AVEN, Marietta, recently moderated a panel discussion at the Academy of Medicine in Atlanta.

Secretary Tom F. Whayne, of the American Board of Preventive Medicine, has advised VIRGINIA D. HAMILTON, of Cartersville, that she has successfully passed the examination for certification in public health work.

JOHN M. HODGES, Marietta; ROBERT C. BEHRENS, Smyrna, and WILLIAM R. EDWARDS, Austell, have been appointed to study hospital needs in the South Cobb area in view of building a general hospital.

DR. and MRS. REMER Y. CLARK, DR. and MRS. ALFRED O. COLQUITT, JR., and DR. and MRS. MURL M. HAGOOD, of Marietta, have recently returned from Ponte Vedra Beach, Fla., where they spent their vacation.

Eighth District

RALPH A. TILLMAN, Pearson, has been named to the Atkinson County School Board.

During the commencement exercises at Tulane University, THOMAS H. CLARK, of Douglas, received a second diploma in honor of his 50th graduation anniversary from the university.

J. W. WALLACE of Douglas, medical advisor for the local Selective Service Board for the past 15 years, was awarded a 15-year certificate and pin by the Board.

Ninth District

COURTNEY C. BROOKS, formerly of Blue Ridge, recently moved to Decatur.

CHARLES H. LITTLE and GEORGE D. GOWER have opened a new clinic in Blairsville.

THOMAS N. PIRKLE has moved from Blue Ridge to Jacksonville, Florida.

A. A. ROGERS, Commerce, has been elected a member of the City Board of Education.

Tenth District

Having been engaged in the practice of general medicine in Milledgeville, WILBUR BAUGH has moved to Augusta where he will specialize in radiology at Talmadge Memorial Hospital.

F. M. McELHANNON, having completed his surgical training at the Vanderbilt Medical Center, Nashville, Tenn., has moved to Athens and is associated with JAMES J. McDONALD in the practice of general surgery.

DR. and MRS. JAMES M. BAZEMORE, Augusta, recently attended the reunion of the graduates of the Class of 1935 from the Medical College of Georgia.



COUNCIL MEETING MINUTES

THE MEETING OF THE Council of the Medical Association of Georgia was called to order by Council Chairman J. G. McDaniel at 2:15 P.M., June 25, 1960 at the Holiday Inn, Macon, Georgia.

Council members present included: Milford B. Hatcher, Macon, President; Fred H. Simonton, Chickamauga, President-Elect; Luther H. Wolff, Columbus, Immediate Past President; Braswell E. Collins, Macon, Second Vice President; John T. Mauldin, Atlanta, Secretary; Charles T. Brown, Guyton, First District Councilor; George R. Dillinger, Thomasville, Second District Councilor; Virgil B. Williams, Griffin, Fourth District Councilor; J. G. McDaniel, Atlanta, Fifth District Councilor; Charles S. Jones, Atlanta, Fifth District Vice Councilor; George H. Alexander, Forsyth, Sixth District Councilor; W. H. M. Weaver, Macon, Sixth District Vice Councilor; Ralph W. Fowler, Marietta, Seventh District Councilor; F. G. Eldridge, Valdosta, Eighth District Councilor; James M. Hicks, Brunswick, Eighth District Vice Councilor; P. T. Scoggins, Commerce, Ninth District Vice Councilor; M. A. Hubert, Athens, Tenth District Vice Councilor; Eustace A. Allen, Atlanta, AMA Delegate; Henry H. Tift, Macon, AMA Delegate, and C. Raymond Arp, Atlanta, Treasurer. Also in attendance were: John P. Heard, Decatur; Public Service Committee Chairman; Lester Rumble, Jr., Atlanta, C. W. Long Memorial Committee Chairman; J. Frank Walker, Legislation Committee Chairman; R. M. Reifler, Macon, American Cancer Society; John T. DuPree, Macon, Bibb County Medical Society; Mr. Frank Shackelford, Atlanta, MAG Attorney and Messrs. Milton D. Krueger and John F. Kiser of the Headquarters Office.

After the invocation, Council Chairman McDaniel called on Mr. Krueger to read the minutes of previous Council meetings. Mr. Krueger read the Council and Executive Committee of Council meeting minutes of April 30, 1960 which were duly approved. Mr. Krueger then read the Council and Executive Committee of Council meeting minutes of May 4, 1960. On motion duly made and seconded, the minutes of the Council of the Medical Association of Georgia meeting May 4 were corrected to read in the item concerning Date and Site of Next Council Meeting as follows: "George A. Alexander, Milford B. Hatcher, Braswell E. Collins, W. H. M. Weaver, and Henry H. Tift invited the Council to meet in Macon for the next meeting and it was voted to accept the invitation of these physicians as hosts to meet in Macon during the month of June for the next Council meeting and further that the date of this meeting be left to the Executive Committee of Council." There being no other corrections, on motion duly made and seconded, the Council and Executive Committee of Council meeting minutes of May 4, 1960, as corrected, were then approved.

MAG Fifty Year Pin Caduceus

Secretary John T. Mauldin presented a communication of May 9 from R. C. Williams which brought to the attention of the Association the fact that the caduceus now used on the MAG

Fifty Year Awards has two serpents representing commerce and not medicine. The communication further stated that one serpent is the correct symbol for medicine. Dr. Mauldin explained that the jewelry firm making these pins concurred that the one serpent symbol is correct for the profession of medicine. Dr. Mauldin advised the Council that a die for the correct symbol would cost approximately \$30.00, should such a change be desirable. On motion (Collins-Dillinger) it was approved that a die be used after the present supply is exhausted and further that the cost of the die be charged to the budget at the discretion of the Finance Committee Chairman.

Teenage Program on Cigarettes and Lung Cancer

Secretary Mauldin presented a letter from A. B. Conger requesting Council consideration and approval of the American Cancer Society Program material on "Teenage Program on Cigarettes and Lung Cancer." This program consists primarily of the showing of a film strip with a recorded narration at various schools, YMCA's, clubs, etc., with accompanying literature. R. M. Reifler, representing the Cancer Society further clarified this program. After viewing the filmstrip "To Smoke or Not to Smoke," on motion by George R. Dillinger and duly seconded, it was approved that the MAG Council approves this "Teenage Program on Cigarettes and Lung Cancer" with the stipulation that such program be presented under medical ethical standards and, if possible, that a physician should be present at the showing of the filmstrip.

SAMA Annual Meeting Travel Expenses

Secretary John T. Mauldin read correspondence from Mr. Robert P. Taylor, President of the Student American Medical Association Chapter at the Medical College of Georgia. This correspondence concerned the travel expenses of one SAMA Delegate from the Medical College of Georgia in connection with attendance at the recent SAMA annual meeting, Los Angeles, California. Dr. Mauldin stated that the Delegate's expenses were \$305.70. After discussion, it was noted that \$500 had been appropriated for both medical schools should they wish to send delegates, with the proviso that \$250 be available to each school, if MAG is so notified 60 days in advance of the annual SAMA meeting. If the balance of the sum is not used by the other school, such monies would be available for the school sending a representative. On motion made by Dr. Hatcher and duly seconded, it was approved that \$250 be sent the representative of the Medical College of Georgia even though notification was not given in advance of the meeting and that it be clarified to the representative as to why the full bill of \$305.70 would not be covered.

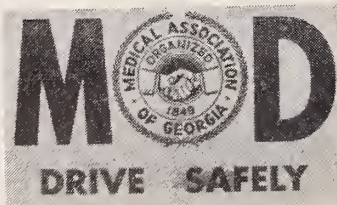
Council Policy on Miscellaneous Items

Council Chairman J. G. McDaniel requested Council policy on the issuance of credit cards for both telephone and airline by the MAG. After discussion, on motion (Dillinger-Williams) it was approved that credit cards be annually issued by MAG, as was approved by Executive Committee, and further that the issuance of these credit cards be reviewed by Executive Committee annually, and further that their issuance be terminated after the conclusion of the issues term of office.

Dr. McDaniel then requested Council policy on the charging of expenses of the secretary. After discussion of this matter, on motion made by Dr. Hatcher and duly seconded, it was approved that expenses for the secretary of an official nature be charged to the MAG under the budget item known as Headquarters

MAG SAFETY STICKER

THE MEDICAL ASSOCIATION OF GEORGIA is pleased to make available to its individual members an automobile bumper "safety sticker" bearing the inscription "M.D" and "Drive Safely" with the official MAG seal. The safety sticker will be mailed to any MAG member upon



his written request for a *single* sticker. New MAG members now receive this safety sticker automatically with their MAG membership card at no charge. Members should address their request to: Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta 9, Georgia.

Office travel and that these expenses be carried as a separate budget item.

Dr. McDaniel also requested Council policy on the chairmanship of the AMA delegation for planning and attendance of the AMA Annual and Clinical Sessions. On motion duly made and seconded, it was approved that the senior AMA Delegate would be the Chairman of the MAG-AMA delegation.

MAG Monthly Budget Report

Virgil B. Williams, Chairman of the Finance Committee reviewed the MAG 1960 budget as of May 31, 1960. After a thorough and complete discussion of the MAG budget, it was moved (Scoggins-Dillinger) that \$5,000 be taken from the general fund and transferred to the contingent fund and this motion was approved. On motion duly made and seconded, the monthly budget report by Dr. Williams was approved and accepted for information.

1960 MAG Annual Session Budget Report

Henry H. Tift, Chairman of the MAG Annual Session, presented a complete report of the budget for the 1960 Annual Session held in Columbus, Georgia. It was noted that this was deficit budget. On motion (Hatcher-Simonton) it was voted to commend Henry H. Tift as Chairman of the 1960 Annual Session and approve and accept his report. It was further recommended that the budget deficit be charged to the contingent fund.

Enlargement of Council

Mr. Francis Shackelford, MAG Attorney, presented a plan for election of Councilors and Vice Councilors having 100 or more active members for the enlargement of MAG Council according to the May 4, 1960 change in the MAG Constitution and Bylaws. This plan, as suggested by Mr. Shackelford is as follows:

Article VI, Section 1 of the Constitution provides that the Council shall include, among others, "Councilors as provided for in the Bylaws" and Chapter IV, Section 1 of the Bylaws states that the Council shall include one Councilor or Vice Councilor "from each Councilor District" and from "County Medical Societies having 100 or more active members." Concerning Councilors and Vice Councilors from such Medical Societies, the Bylaws provide as follows:

"Component County Medical Societies having 100 or more active members shall be entitled to elect one Councilor and one Vice Councilor directly representing that society. In these elections, only those members residing in the district outside the large county medical society may vote for the Councilor representing that district."

Chapter V, Section 1 of the Bylaws provides that Councilors and Vice Councilors "shall serve for three years" and that "One-third of the Councilors and Vice Councilors shall be elected annually." Presently one-third of the Councilors and Vice Councilors are not elected annually but instead four of each are elected in one year, four of each in the following year and two of each in the next year.

Article VI, Section 2 of the Constitution states that the Council shall carry out "the mandates and policies as determined by the House of Delegates" and that its duties shall include such duties "as may be prescribed in the Bylaws." Chapter IV, Section 5, of the Bylaws provides that "Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and Bylaws." The Constitution and Bylaws having been adopted by the House of Delegates and the Bylaws providing that one-third of the Councilors and Vice Councilors "shall be elected annually," it is in our opinion the mandate of the House of Delegates that the Council implement the Bylaws by establishing procedures to insure the election of one-third of the Councilors and Vice Councilors annually.

Under the Constitution and Bylaws, as amended, there will now be a total of 15 Councilors and 15 Vice Councilors—one Councilor and Vice Councilor from each of the 10 Districts and one Councilor and Vice Councilor from each of the five county medical societies having 100 or more members. These county societies in question are those in Bibb, Chatham, Fulton, Muscogee, and Richmond counties. To provide for the election of one-third of the Councilors and Vice Councilors each year, we recommend that the Council achieve this result through the following steps:

- 1. Have the Councilors and Vice Councilors who are members of the five county societies now entitled to elect their own Councilor and Vice Councilor submit letters of resignation now effective at the annual meeting of the Asso-

ciation in 1961. The Councilors and Vice Councilors in question are Dr. Peterson (Chatham County Medical Society), Dr. Jordan (Muscogee County Society), Dr. McDaniel and Dr. Jones (each of Fulton County Medical Society), and Dr. Alexander and Dr. Weaver (each of Bibb County Medical Society).

- 2. In addition to the normal election at the annual meeting of the Association in 1961 of Councilors and Vice Councilors from the First, Second, Third, and Fourth districts, elect a Councilor and Vice Councilor at the same time from the Chatham County Medical Society to serve for three years.

- 3. Elect at the annual meeting of the Association in 1961 a Councilor and Vice Councilor from Muscogee County to serve until 1962 when Councilors and Vice Councilors would be elected from such county society and the Fifth, Sixth, Seventh, and Eighth districts to serve three full years.

- 4. Elect at annual meeting of Association in 1961 a Councilor and Vice Councilor from Fulton, Bibb, and Richmond county medical societies to serve until 1963 when Councilors and Vice Councilors from such societies and the Ninth and Tenth districts would be elected to serve three full years.

For your ready convenience, we are enclosing a schedule of suggested annual elections providing ultimately for election of one-third of Councilors and Vice Councilors yearly. If you should have any questions concerning this matter, please be sure to call on us.

Schedule of Suggested Annual Medical Association of Georgia Elections Providing Ultimately for Election of One-Third of Councilors and Vice-Councilors Annually

- 1. At the 1961 annual meeting of the Association, the following Councilors and Vice Councilors would be elected to serve until the date indicated:

- Districts 1. (1964)
2. (1964)
3. (1964)
4. (1964)
Chatham County Medical Society (1964)
Muscogee County Medical Society (1962)
Bibb County Medical Society (1963)
Fulton County Medical Society (1963)
Richmond County Medical Society (1963)

- 2. At the 1962 Annual Meeting of the Association, the following Councilors and Vice Councilors would be elected to serve for three years:

- Districts 5. (1965)
6. (1965)
7. (1965)
8. (1965)
Muscogee County Medical Society (1965)

- 3. At the 1963 annual meeting of the Association, the following Councilors and Vice Councilors would be elected to serve for three years:

- Districts 9. (1966)
10. (1966)
Bibb County Medical Society (1966)
Fulton County Medical Society (1966)
Richmond County Medical Society (1966)

- 4. At the 1964 annual meeting of the Association, the following Councilors and Vice Councilors would be elected to serve for three years:

- Districts 1. (1967)
2. (1967)
3. (1967)
4. (1967)
Chatham County Medical Society (1967)

After due discussion of the Shackelford plan, Secretary Mauldin discussed an alternative plan for consideration, should any of the present Councilors or Vice Councilors not wish to resign effective May 7, 1961 as suggested in the Shackelford plan. After discussion of the alternate plan, on motion (Jones-Wolff) it was voted and approved to accept the report proposed by Mr. Shackelford as official Council policy in implementing the recent change in the MAG Constitution and Bylaws.

Report on National Legislation

Eustace A. Allen, Vice Chairman of the MAG Legislative Committee presented a report concerning national legislation

now pending in the Congress. He cited AMA policy on Health Care for the Aging as set forth at the June 13-17 AMA Annual Meeting. He then discussed Title 6 (Medical Care Provisions) of H.R. 12580 now pending in the Senate. On motion (Dillinger-Alexander) it was voted that Council approves Title 6 (Medical Care Provisions) of H.R. 12580.

At this time, Council Chairman J. G. McDaniel appointed a committee to draft a policy statement on the approval of this bill so that the committee could present this statement to Council for its consideration on the following day. The committee consisted of President Milford B. Hatcher, Secretary John T. Mauldin, President Elect Fred H. Simonton, Legislative Committee Vice Chairman Eustace A. Allen, and Legislative Committee member J. Frank Walker.

Chairman McDaniel recessed the June 25 Council meeting at 5:30 P.M.

Council Reconvened

Council Chairman J. G. McDaniel reconvened the Council meeting at 8:10 A.M., June 26, 1960, in the Holiday Inn at Macon, Georgia.

Dr. McDaniel called on James T. Hicks who delivered the Invocation.

Chairman McDaniel then called on President Hatcher for a report of the Committee concerned with the policy statement on Title 6 (Medical Care Provisions) of H.R. 12580 now pending in the Senate. Dr. Hatcher presented the following policy statement for the consideration of the Council:

"The Medical Association of Georgia reaffirmed its interest in maintaining the highest standards of health and medical care for all the people of Georgia, irrespective of age or financial status.

"The Medical Association of Georgia will continue to support those measures that will improve the quality of medical care for the people of Georgia and will oppose those measures which are hastily conceived and politically expedient.

"The MAG supports Title 6 (Medical Care Provisions) of H.R. 12580 which provides for the medical care of the aged and urges its adoption by the Senate as passed by the House of Representatives on June 23, 1960."

On motion (Alexander-Collins) it was voted to adopt this statement as official MAG policy on this matter.

Dr. Allen then continued his report on national legislation with a June 22 letter concerning an AMA regional Legislative Meeting, August 12-13, 1960, to be held at French Lick, Indiana. The purpose of the meeting was discussed and on motion (Wolff-Williams) it was voted that two MAG representatives attend this meeting and that their expenses be paid and charged to the contingent fund. The motion further stated that Associate Executive Secretary, Mr. Kiser and one physician, selected by the President, would be the representatives of the MAG at this meeting.

The inclusion of physicians under Title II, OASDI, (Social Security) was also discussed by Dr. Allen and on motion (Wolff-Collins) it was moved that telegrams be sent to the two Georgia Senators and the Chairman of the Senate Finance Committee reaffirming MAG opposition to the inclusion of physicians under the Social Security Act.

AMA Delegates Report

Henry H. Tift, MAG-AMA Delegate, presented a complete report of the action of the AMA House of Delegates' recent meeting June 13-17, 1960, at Miami Beach. He discussed in detail the three resolutions presented by the MAG and the other actions of the AMA House. In discussion pertaining to his report, it was recommended that activation of MAG interest in para-medical recruitment be referred to the Hospital Relations Committee and further that this Committee report on their activity to the Council at the Council September meeting.

Drs. Tift and Allen discussed with the Council the possibility of MAG considering the payment of the MAG-AMA Delegates expenses at AMA's annual and clinical sessions. By agreement, it was recommended that this matter be discussed at the September meeting of Council.

Other National Legislation

Members of the Council again discussed national legislation in Congress concerning the health care of the aged. On motion made by Dr. Dillinger and duly seconded, it was voted that the Executive Committee be empowered to send a delegation to Washington, if deemed necessary.

MAG House of Delegates 1960 Action

Council Chairman McDaniel presented certain actions directed to MAG Council for implementation as follows:

A recommendation made by the Chairman of the MAG Committee on Rehabilitation requesting a sum of money, not to exceed \$500, for the preparation of a handbook on rehabilitation services and facilities in the State of Georgia. By general agreement, it was recommended that the Chairman of this Committee be asked to attend the September Council meeting and further explain this project.

Two recommendations for the reorganization of the committee structure of the Association. It was noted that the Council Committee on Committee Reorganization led by George R. Dillinger was already active in this field. Dr. Dillinger stated that he would have recommendations for the Council as soon as possible.

The commendation of Coweta County Medical Society for their splendid work in collecting a vast amount of drugs for use in a Korean Hospital. On motion (Scoggins-Hatcher) it was voted that the Coweta County Medical Society be so commended by the Council and that the Secretary notify the society of this commendation.

Headquarters Office Report

Executive Secretary Mr. Krueger reported on the meetings attended and/or staffed by the members of the Headquarters Office since May 4, 1960. He also reported on the main projects now in progress in the Headquarters Office. Mr. Krueger discussed personnel in the Headquarters Office and by general agreement this report was accepted for information and Mr. Krueger commended on his activity as Executive Secretary.

Public Service Committee Report

Public Service Committee Chairman John P. Heard presented a recommendation that the MAG "Presidents and Secretaries Conference" be held in December instead of March. He believed the timing of the meeting in December would prove more advantageous for those county medical society officers attending. To implement this change in date, Dr. Heard cited the need of \$1500 to hold the Conference. He explained this could not have been budgeted during the year 1960 because the 1960 Conference had already been held in March of 1960. On motion (Williams-Alexander) it was voted that the "Presidents and Secretaries Conference" be held in December at the MAG building, if at all possible, and that \$1500 be appropriated from the contingent fund for this purpose.

Dr. Heard then presented a recommendation that the MAG publish a quarterly bulletin for distribution to all members and that a pilot bulletin of this type be published early in the fall. He stated that he believed that better communication between the MAG and its membership was necessary and that this bulletin could accomplish this end. Dr. Heard reported that an issue of the bulletin would probably cost \$800. On motion (Simonton-Dillinger) it was voted to suggest to Dr. Heard that this recommendation concerning the bulletin publication be put in his report to the House of Delegates so that the House of Delegates might best consider the value and advantage of this project.

Corporate Practice of Medicine

Lester Rumble, Jr., representing the Georgia Society of Anesthesiologists, requested the cooperation of the Council of the Medical Association of Georgia in making the advice of the Association's attorney available in connection with a resolution of the anesthesiologists concerning the corporate practice of medicine. By general agreement, this matter was referred to Dr. Scoggins, President of the State Board of Medical Examiners, who will request a legal opinion of the Attorney-General.

Crawford W. Long Memorial Report

Lester Rumble, Jr., Chairman of the Crawford W. Long Memorial Committee, gave a report on the status and activity of the Crawford W. Long Memorial in Jefferson, Georgia. After his report, he stated that he wished to do an all member mailing to the physicians in Georgia seeking contributions for the Memo-

rial. On motion (Alexander-Collins) it was voted that the Crawford W. Long Memorial Committee be permitted to do an all member mailing and that the expense of this mailing be borne by the Association and charged to the contingent fund.

Blue Shield Policy on Participating Physicians

President Milford B. Hatcher described a situation in which a list of participating physicians in the Blue Shield plan had been posted and he stated that President Hatcher write the Blue Shield about this matter requesting them not to post a list of participating physicians.

Unfinished Business

Secretary Mauldin read a letter of appreciation from Miss Anne Whiddon thanking the Council of the Medical Association of Georgia for a wedding gift presented to her by the Association on the occasion of her marriage to Dr. James J. Kirkland.

Secretary Mauldin then read a letter of appreciation from Mr. John D. Arndt, former MAG Medicare Administrator, in which Mr. Arndt expressed his thanks for the award by the MAG of a Certificate of Appreciation.

Secretary Mauldin then read a letter written in behalf of the MAG to Delta Air Lines expressing appreciation to Delta for their cooperation in making flight space available to Dr. and Mrs. Charles A. Doan of Columbus, Ohio, so that they might attend the recent Miami, 1960 AMA session to receive the 1960 AMA Distinguished Service Award.

New Business

Charles T. Brown, Councilor for the First District, invited the MAG Council to meet at Highlands, North Carolina on September 3 and 4, for the regular September meeting of Council. By general agreement, the Council tentatively accepted this invitation, if room space could be found for Council members and their wives in attendance at this meeting. It was further recommended that should room space not be available, the Executive Committee of Council would designate the date and site of the September Council meeting.

Fred H. Simonton recommended that a plaque be placed in the Headquarters Office with the names of the present officers of the Association designated on this plaque. It was recommended that Dr. Simonton investigate the type and cost of such a plaque and further report on this matter at the September meeting of the Council.

On unanimous motion, which was duly approved, it was voted that the Council express its appreciation to Dr. and Mrs. Milford B. Hatcher, Dr. and Mrs. Braswell E. Collins, Dr. and Mrs. George H. Alexander, Dr. and Mrs. W. H. M. Weaver, and Dr. and Mrs. Henry H. Tift for their most gracious hospitality to the MAG Council on the occasion of this Council meeting and further that the Association Secretary write these physicians and their wives in behalf of Council.

MAG Council Chairman J. G. McDaniel welcomed the following new members of Council attending this session: John T. Mauldin, Atlanta, Secretary; Braswell E. Collins, Macon, Vice President; M. A. Hubert, Athens, Tenth District Vice Councilor; J. Frank Walker, Atlanta, Vice Speaker, and W. H. M. Weaver, Sixth District Councilor.

There being no further business, the meeting of the MAG Council was adjourned at 12:05 P.M.

EXECUTIVE COMMITTEE OF COUNCIL MEETING MINUTES

THE JUNE MEETING of the Executive Committee of Council was called to order at 12 noon, Sunday, June 26, 1960 at the Holiday Inn, Macon, Georgia by Chairman Milford B. Hatcher.

Also present in addition to Dr. Hatcher were: J. G. McDaniel, Fred H. Simonton, John T. Mauldin, Virgil B. Williams, and Messrs. Krueger and Kiser of the MAG Headquarters Office.

Auto Stickers

Mr. Krueger requested permission to issue MAG auto stickers free to members upon their written request. He stated the Association had been charging 50 cents for each sticker in the past. On motion (McDaniel-Williams) it was voted to issue these stickers free to any member upon written request and it was further voted that a notice of this action be published in the *Journal*.

World Medical Association Request

Mr. Krueger presented a request by the World Medical Association to use the MAG mailing facilities to mail a news release

to all members concerning the appointment of Dr. Charles W. Hock of Augusta as State Chairman of WMA. It was voted to approve this request.

Southern Medical Association Request

Mr. Krueger presented a letter from SMA requesting MAG's views on whether SMA should expand its services to members particularly in the area of socio-economic medicine. It was voted that the Secretary inform SMA that the Association has no suggestions to make on this matter at the present time, but that this subject will be given some thought by MAG officers.

TB Inter Agency Committee Appointed

Carl C. Aven of Marietta was reappointed as one of MAG's representatives on this Committee.

MAG Legislation Committee Chairman

Dr. Hatcher presented a letter of resignation from J. Frank Walker as Chairman of Legislation. This resignation as Chairman was accepted with regret by Executive Committee and John A. Bell of Dublin was appointed Chairman of the Committee succeeding Dr. Walker.

Rural Health Committee Appointment

Mr. Krueger presented a letter from Katrine R. Hawkins resigning from the Rural Health Committee and it was voted to request the Chairman of the Committee to submit three names for appointment at the next meeting of the Executive Committee.

State Rural Development Committee

Mr. Krueger presented a letter from the Cooperative Extension Service in Agriculture and Home Economics requesting an MAG representative to serve on the State Rural Development Committee and it was voted to appoint Albert L. Morris, Chairman of the Rural Health Committee, to serve in this capacity.

Public Service Appointments

The following appointments were made to the Committee on Public Service: John P. Heard, Decatur, Chairman (1961); E. P. Inglis, Marietta, Vice Chairman (1963); T. Gray Fountain, Albany (1963); Oscar H. Lott, Savannah (1963); E. C. McMillan, Macon (1961); A. H. Letton, Atlanta (1961); William E. Barfield, Augusta (1961); Simone Brocato, Columbus (1962); Albert M. Boozer, Dalton (1962), and Alex P. Jones, Griffin (1962).

Rehabilitation Committee Appointment

Mr. Krueger presented a letter in which Hal S. Raper of Warm Springs had resigned from this Committee. It was voted to appoint Thomas P. Goodwyn of Atlanta to succeed Dr. Raper on this Committee.

Cancer Committee

Dr. Hatcher read a letter from Hoke Wammock, Chairman of the Cancer Committee requesting that the following be named to the Executive Committee of this Committee: Everett L. Bishop, Atlanta; J. E. Scarborough, Atlanta; R. C. Pendergrass, Americus; Thomas Harrold, Macon; Neal F. Yeomans, Waycross; John T. Mauldin, Atlanta, and Enoch Callaway, LaGrange. It was voted to approve this request.

Headquarters Building

Dr. Mauldin discussed several problems in connection with the purchasing of additional furniture and equipment for the new building. The discussion included purchase of additional chairs for the meeting room, chairs for the Council room, and a podium for the large meeting room. It was generally agreed that Dr. Mauldin complete the purchase of furniture as previously outlined.

Next Meeting

After discussion, it was voted to hold the next meeting of the Executive Committee at 3:00 P.M., Saturday, July 23, at Dr. Simonton's Farm, Centralhatchee, Georgia.

There being no further business, the meeting was adjourned at 1:00 P.M.

PUBLIC SERVICE COMMITTEE MEETING

THE FIRST ORGANIZATIONAL meeting of the MAG Committee on Public Service was called to order at 4:15 P.M., Wednesday,

the association CONTINUED

June 29 in the MAG Headquarters Office Building, Atlanta, by Chairman John P. Heard, Decatur.

Also present were committee members E. P. Inglis, Marietta, vice chairman; A. H. Letton, Atlanta, and Alex P. Jones, Griffin.

Also present was Mr. John F. Kiser of the MAG Headquarters Office staff.

Dr. Heard and members of the Committee discussed the lack of attendance at Public Service Committee meetings and several suggestions were made including changing the day of the week on which the meetings were held. It was also suggested that a more personal and detailed appointment letter be sent to committee members on the occasion of their original appointment.

The next item of business was a discussion of a County Society Officers Indoctrination Conference scheduled to be held on December 11, 1960. The following topics were suggested for inclusion on the program of this one-day conference:

- (1) Specific Public Relations Programs
- (2) The Basic Eight
- (3) Secretary's Kit (Explanation)
- (4) Press Relations
- (5) Medical Discipline
- (6) Problems of Television and Radio—
Medical Milestones
- (7) How to Stay in Contact with Local News Media.

The members of the Committee discussed this conference at great length and also the problems related to it, such as request-

ing county societies to change the date of election of their officers so that the president-elect and secretary-elect could attend this conference in December before taking office in January.

The possibility of a health fair at the time of the annual session in Atlanta in May, 1961 was discussed by the members of the Committee. Dr. Letton pointed out that the Fulton County Medical Society is sponsoring a whole section of exhibits during the Southeastern Fair in October in Atlanta. Following further discussion, it was voted to request the Chairman to write a letter to the Fulton County Medical Society Board of Trustees requesting their views on this matter.

For information of committee members, Dr. Heard discussed the possible publication of an MAG Newsletter. He pointed out that funds for this newsletter had been turned down by Council. General discussion on the newsletter followed.

The next item of business concerned a proposal originated by the Iowa State Medical Society which calls for a meeting with representatives of the press to hear their views on the medical profession and their suggestions for improvement of public relations programs. This was discussed in general and Dr. Letton described the activities of the Fulton County Medical Society in this area. He pointed out that a dinner was held last year for the press in the Atlanta area and that another one will probably be held this year.

Dr. Heard announced the annual AMA PR Institute to be held in Chicago, September 1-2, 1960 and following discussion, it was voted to urge county medical societies to send representatives to this conference.

Dr. Jones brought up the matter of automobile safety and various activities in this area were discussed. Dr. Heard reviewed MAG's liaison with Colonel Trotter last year and other information related to automobile safety.

There being no further business, the meeting was adjourned at 6:20 P.M.

AUXILIARY'S EXECUTIVE BOARD AND ADVISORY BOARD MEET

THE EXECUTIVE BOARD of the Woman's Auxiliary to the Medical Association of Georgia, in session recently at Radium Springs, formulated its plans for the 1960-1961 year of auxiliary work.

The Auxiliary's advisory board, composed of seven physicians representing the Medical Association of Georgia, joined the Auxiliary during their meeting to discuss their new plans and make suggestions.

Virgil B. Williams of Griffin, chairman of the advisory committee, commended the Auxiliary and the national auxiliary on its chosen theme for 1960-1961, "To Preserve and Enhance the Heritage of American Medicine."

Milford B. Hatcher of Macon, president of the MAG, informed the Auxiliary board of recent MAG developments for which their support was sought.

Members of the Advisory Committee are: Virgil B. Williams, Griffin, chairman; Remer Y. Clark, Marietta; W. G. Elliott, Cuthbert; Milford B. Hatcher, Macon; W. P. Rhyne, Albany; Fred H. Simonton, Chickamauga, and Luther H. Wolff, Columbus.



Members of the Advisory Committee to the Woman's Auxiliary to the Medical Association of Georgia that attended the meeting of the executive board of the Woman's Auxiliary held at Radium Springs were, left to right, Virgil B. Williams, Griffin; Luther H. Wolff, Columbus; Remer Y. Clark, Marietta; Milford B. Hatcher, Macon, and W. G. Elliott, Cuthbert.



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Cover:

Fifteen days in a laboratory "space ship"—locked in a flight station in the Lockheed Human Factors Research Laboratory at Marietta for 15 days, a Strategic Air Command pilot from Eglin Air Force Base, Fla., Capt. William Lane of Gadsden, Ala., works on space-travel type problems while all his reactions are recorded. Photograph courtesy Lockheed Aircraft Corporation.

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A MENTAL HYGIENE PROGRAM FOR GEORGIA

A prime feature of any successful program is to change the attitudes of the general public so that the stigmas of mental disease can be removed.

Irville H. MacKinnon, M.D., *Milledgeville*

THE MENTAL HEALTH DIVISION of the State Department of Public Health is an all inclusive organization dealing with all aspects of psychiatric service. There are two main divisions, one that deals with the preventive procedures, the educational programs in the community, and the conduction of or the subsidizing of psychiatric facilities in clinics, intensive treatment centers in hospitals, or in medical school units. The other division deals with the various state hospitals which accept for admission and therapy those cases too ill to be cared for in a clinic or general hospital. These patients are mostly accepted on a commitment basis, although a few voluntary patients are admitted.

This presentation will only deal with the functions of the State Mental Hospital units' contribution to the development of a well organized mental hygiene program as it is directly related to the community.

The State Mental Hospital has been in existence long before the development of community psychiatry. As a matter of fact, the latter is a relatively recent achievement and originally was formulated as an extension of the State Hospital services into the areas and communities surrounding the institution and was staffed by the psychiatrists from the State Hospital. A dichotomy, however, became a necessity. With the progress of modern psychiatry, it was more than any mental hospital could adequately supply, especially when its own intrinsic

problems required a better utilization of its own resources.

This does not mean that these two services are working separately or independently of each other. On the contrary, a most intimate and cooperative means of working together is essential in a total psychiatric approach to a well organized and successful mental hygiene program.

The Milledgeville State Hospital is the only mental hospital in a large state. This means that patients, who are acutely ill, are driven long distances from their homes. This has its many disadvantages, as it is difficult to obtain satisfactory social histories, essential and necessary to understand the development and course of a patient's illness. Many patients are admitted with little history or information, making it difficult to understand the patient's illness. Also, at such great distances, it is inconvenient and costly for parents and relatives to visit the hospital. This places a great hardship upon not only the relatives but also the patient, who loses contact with his loved ones at home.

State Hospital Too Large

This hospital is also too large and really represents six hospitals built into one. It has been found by experience in other states that the average size of a hospital should be about 2,000 patients.

For centuries the site of a psychiatric hospital was selected on the basis of complete isolation and as far away from civilization as possible. Patients were soon forgotten and out of complete contact

Presented at the *106th Annual Session of the Medical Association of Georgia, May 2, 1960, Columbus, Georgia.

MENTAL HYGIENE PROGRAM/MacKinnon

with the outside world. This type of location has been found, through time and experience, to be detrimental to modern psychiatric care.

It has been demonstrated that new hospitals that have been built close to the cities and near educational centers have the advantages of not only teaching and consultation facilities, but are able to enlist better physicians, nurses, and attendants. The shortages found in hospitals located in remote locations make it impossible to provide adequate care and attention, and recruitment becomes a serious problem. The proximity of a medical school assures teaching of students which adds prestige and atmosphere. The bringing of departments of psychiatry in a medical school to the State Hospital not only improves the interest and quality of the medical staff, but also is an incentive to medical students to seek internships and residencies in the psychiatric field. The physical and organic aspects of the psychiatric patient, likewise, will receive better study and investigation where well trained specialists are available to furnish expert opinions. Finally, research facilities and the development of investigative procedures are essential, not only to discovering etiological factors, but also better treatment measures in the elimination of mental diseases. The availability of neurophysiologists, neurochemists, pharmacologists, neuropathologists, sociologists, psychologists, medical geneticists, and other research workers, who are qualified and have the facilities to do research, makes it possible to stimulate interest in the psychiatric speciality.

Hospital Must Function

In spite of all these negative conditions which make it difficult to operate, the hospital must function and serve its purpose. It will take a great deal of reorganization and renovation to make it provide efficient care and satisfactory operation. This will require considerable administrative ingenuity, not only on the part of the central offices of the Health Department, but also the direction at the hospital level itself. There is no doubt that Georgia's increasing population will require additional new hospitals, but I am sure that their location will receive close scrutiny.

During the last year there has been a great deal of emphasis focused on the mental hygiene needs by the people of Georgia. There are many factors that have been responsible for this progress. Psychiatry has become a more accepted speciality and the former metaphysical attitudes have been replaced with modern, scientific, factual thinking. Education

has played an important role in acquainting the public with the nature of mental disease, making it more understood and eliminating many fears related to insanity. Curiosity about the subject has created an interest that has been kindled by newspapers and publicized by radio and television. At present the public is requesting better attention and facilities for nervous and mental patients. These pressures and enthusiastic demands bring legislative and political assurances for economic assistance in formulating modern programs. This also makes it a convenient time for psychiatry to take advantage of the situation in keeping the subject activated and pursuing its goals.

Change Attitudes of Public

The important feature of any mental hygiene program is to change the attitudes of the general public so that the stigmas of mental disease can be removed. I do not know of any other factor which will do more to help the progress of the psychiatric approach for the nervous or mental patient. We at the hospital are constantly pursuing this issue, as this is our greatest obstruction interfering with people seeking psychiatric help and keeping them well after they leave the hospital. The acceptance of mental disease by the public as an illness is the foundation for developing the most substantial advances in psychiatric progress.

For the patient to find out that he is going to a hospital and not an asylum of no return will do more for a mental hygiene program in Georgia than anything else. The medical atmosphere of a hospital with doctors, nurses, and attendants trained to utilize the same procedures and approaches found in any modern medical center, will dispel the fears of the mental patient and make it a more desirable place to voluntarily select psychiatric care. The satisfied patient and his relatives are the ones who will give the hospital its reputation. The community will soon have confidence and gradually the false attitudes and stigmas of a psychiatric institution will be lessened.

New Commitment Laws

There has been a great deal of emphasis on modernizing the commitment laws during the last year and the State Legislature has made some changes that have been beneficial. However, this is a field that requires a great deal more study and investigation. It is unfortunate that a mental disorder must have regulatory laws, but the nature of the process makes it a necessity. Every effort should be made to encourage voluntary admissions to a psychiatric hospital, so that the patient may have the

same privileges as any other medical patient. New laws have been formulated so that a patient is not deprived of his civil rights, but they are still too complicated and much time is wasted in getting the patient to a hospital as quickly as possible. Methods of temporary detention and the transportation procedures give a somewhat criminalistic coloring to the procedures. This is a problem which is embarrassing, not only to the patient, but to his parents and other relatives as well. It serves the purpose of postponing an earlier consideration of hospitalization of the patient, when he would be most liable to receive beneficial results from early treatment.

Open Doors to Visitation

One of the best procedures to educate the general public about mental hygiene is to open the doors of the hospital to visitation. During the last year people from all over the State of Georgia have had the opportunity to really see what a mental hospital is like. Tours have been arranged for civic groups and informative discussions were given to dispel some of their erroneous attitudes. I am sure that everyone went home with an entirely different viewpoint about the insane, especially when they saw them sitting quietly or working in occupational therapy and the many other diversional and recreational activities.

With the introduction of new tranquilizing drugs and shock therapies it is no longer necessary to have excited, disturbed, and destructive patients, which many of the visitors expected to see. Many questions as to their location reveal what the public was anticipating.

Hospital Can Contribute to Education

The State Hospital can also make a contribution to an educational program for the community. The members of psychiatric, social service, and psychological departments should be available as public speakers for the various civic clubs, medical societies, and parent-teacher associations. Programs for the general practitioner should be organized, to acquaint him with the modern methods of diagnosis and the factors responsible for psychiatric disturbances. This would result in a quicker recognition of nervous and mental disease and consequently an earlier placement on specific drug therapies. A closer working together of the general practitioner and other specialists with the medical staff of a state hospital would create a better understanding of each other, as well as an improved psychiatric acceptance. Many physicians have been asking for oppor-

tunities to attend seminars and demonstrations at the hospital which would be instructive and informative. This would also apply to lawyers, judges, clergymen, and teachers. These are the people who are dealing with the problems of the children, adolescents, delinquency, divorces, home problems, and the emotional difficulties affecting their communities. Proper courses given to these people could be of great assistance in providing information and service to their public.

The possible contributions of the community to the successful operation of a state hospital certainly are numerous. At present, one of our biggest problems is the recruiting of personnel. Not only is it difficult to find trained people, but also our hospital budgets are not adequate to develop new positions. This is where a volunteer or a Gray Lady Program can be utilized. In the last six months, eight garden clubs have been organized that are working with a membership of over 400 patients. This is just a beginning and other types of services will be organized. The possibilities in electronics, television, air-conditioning, and numerous trades could be developed with the assistance of local merchants and people trained in these fields, who would volunteer their services for many useful projects. People in the arts and crafts, the musical field, and educators, who could teach our young people with uncompleted high school courses, are a few examples where individuals with spare time, or those who are retired, could find a useful outlet for their energies.

The utilization of college and medical students during the summer months would not only provide tuition funds, but would serve as a source of recruitment for future training in psychiatric and related fields. Where shortages exist, it is necessary to do future planning and organize procedures for the development and training of our own specialists. It may be necessary, as an emergency measure, to import key personnel as a nucleus around which to build a program. This is not the solution to the problem and efforts will have to be made in preparing an independent program that will satisfy our own needs for the future.

Scholarships Encourage Georgia Medical Students

The recent meeting of the State Legislature provided scholarships to encourage Georgia students to accept training in the needed fields. Upon completion they would be obligated for a period of time to serve in a state hospital, or one of the intensive treatment clinics of the Community Mental Health Program. Subsidizing already existing programs is more economical and provides immediate training, instead of waiting to build facilities and import high

MENTAL HYGIENE PROGRAM/MacKinnon

salaried teachers that are difficult to divert into new and unestablished programs.

The State Hospital might be able to provide emergency psychiatric facilities to small counties remote from clinics or intensive treatment centers. It would be more economical, if the child or adult needing examination or treatment could be brought to the State Hospital to an established clinic located there. Because of the shortage of doctors, this would conserve time badly needed. However, it would be possible to establish a traveling clinic of a psychiatrist, social worker, and psychologist, which could provide occasional services in counties where it is most needed. As we are able to recruit more psychiatrists for our hospital, services of this kind could be increased and extended.

The Community Mental Division of the Department of Health is endeavoring to establish clinics in various parts of the state. It will be a long time before follow-up clinics will be available to the discharged and furloughed patients from our hospital. This, however, is the most important means of keeping patients at home. Few people realize that 37 per cent of our patients return to the hospital within a year and sooner, because they had no psychiatric help or anyone to see that the prescriptions for their tranquilizers were refilled. I believe that some of this can be remedied at the State Hospital level, if better arrangements and plans are formulated. This would require that the psychiatrist and the social worker discuss the details with the family, so that they understand the patient's problems and would know how to handle special situations more intelligently. It would also be a good plan to formulate a brief abstract for the family physician and suggest that he supervise the medication, as well as to ask for assistance from the hospital whenever he feels it is indicated.

There are still inadequate facilities available to handle the alcoholics' problems. Good work is being done in the large cities where a clinic is available.

However, this is only scratching the surface, and it is necessary to commit simple acute alcoholics to the State Hospital in large numbers. This is no place to send them for a few days where they quickly become sober. Alcoholics are sick people. Underneath there are serious problems which require intensive therapy and there should be special facilities for them and the numerous drug habitues, but not in a state hospital. We will not refuse to accept these patients and will try to do all we can to handle the situation until some other arrangements can be developed. Alcoholics Anonymous is doing good work and has been coming in a group once a week in the evenings to work with these patients. When the patient is ready to be discharged, arrangements are made in advance with local Alcoholics Anonymous groups to make immediate contact as soon as the patient arrives home. This will prove successful in preventing relapses, and is exactly the same principle involved in an after care follow-up for our other psychiatric cases.

Conclusions

There are many inadequacies in our mental hygiene system, but in closing I cannot help but mention the great need for not only clinic facilities for the children of this state, but also the complete lack of any place to observe, study, and treat children who need institutional care. We are admitting disturbed children to Milledgeville because there is no other place to observe them. The greatest shortages in the field of mental hygiene are child psychiatrists. It doesn't appear that this situation can be corrected in the near future, but at least is a matter that should be looked into and investigated thoroughly.

There is a job to be done. Although difficulties are prevalent, they are not insurmountable. The interest of the public, the cooperation of the profession, and the working out of a logical program with adequate financing will pave the way to future development of a sound mental hygiene program for the State of Georgia.

Milledgeville State Hospital

RURAL HEALTH CONFERENCE TO BE HELD IN ATLANTA

PHYSICIANS AND FARM group representatives from 11 Southeastern states will gather in Atlanta, Ga., Oct. 7-8, for the first regional conference on rural health.

"Joining Hands for Community Health" is the theme of the meeting which will be held at the Dinkler Plaza Hotel and is sponsored by the American Medical Association's Council on Rural Health.

Highlight of the conference will be a banquet address Friday evening, Oct. 7, by Dr. Julian P. Price, Florence, S. C., newly appointed chairman of A.M.A.'s Board of Trustees.

Participants will come from an 11-state area which includes Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North and South Carolina, Tennessee, Virginia, and West Virginia.

RETROGRADE UROGRAPHY IN CHILDREN

This procedure may demonstrate pathology which cannot be visualized by the intravenous route.

Robert M. Tankesley, M.D., *Atlanta*

TODAY, URINARY PATHOLOGY in infants and children as a cause of presenting symptoms is a well recognized frequency. Usually, early in the evaluation of obscure problems the urinary tract is suspected and evaluated, including intravenous urography. However, the I. V. pyelogram may not be sufficient and is often inadequate. In most cases, urinary pathology is suspected on intravenous urography, but it may not be demonstrated. If there is any evidence of urinary abnormality, the retrograde studies, cystography and pyelography, should be done. It has been only in recent years that cystography has been observed in its full significance. The ureterovesical junction is a very important part of the urinary tract. Its function is to be evaluated carefully in any complete study of the urinary tract, especially in infants and children.

In 1948, Stewart¹ demonstrated ureteral reflux on cystography in which the exposure of routine films was accidentally delayed. Delayed cystography technique was adapted and previously unsuspected pathology has been found. Incompetence of the ureterovesical junction is frequently a basic defect in urinary infection, pressure changes, hydronephrosis, hydroureter, and impaired function. After several years experience, Stewart concluded that (1) the degree of bladder distention with contrast medium has no relation to the occurrence of ureteral reflux, (2) reflux does not occur in the normal urinary tract, (3) competence of the ureteral orifice cannot always be determined by its cystoscopic appearance, and (4) if reflux does not occur during delayed cystography, it may occur during voiding.

A number of interesting cases of urinary pathology

have been demonstrated by the urology staff at Eggleston Hospital. Cystography technique is briefly as follows: after preliminary survey of the abdomen, the bladder is fully distended by contrast medium through a small Foley retention catheter. This is best done without general anesthesia. When the child complains of discomfort or a maximum of 150 cc. of medium has been instilled, the catheter is clamped. Serial films may be made during the next hour. Reflux may be detected at any phase of this interval. The catheter is then withdrawn, usually stimulating spontaneous voiding. A post-voiding cystogram is then made. The reflux may be large, with dilatation of the upper urinary tract, or minimal. It may occur immediately, as in bladder neck obstruction, or it may be delayed. The reflux may be lateral, or bilateral; alternating, sustained or recurrent. It can be reproduced. It may outline the upper urinary tract pathology better than excretory or retrograde pyelography. The delayed or voiding cystogram is of particular value in those pediatric patients where intermittent urinary infection is unexplained by cystoscopy and intravenous and even retrograde urography.

Study Made of Bladder Size

Rothfeld and Epstein² made a study of bladder size to determine a criteria for normal. The bladder in the cases studied appeared large, but cystometric studies indicated that they were normal. The normal bladder cystogram has a smooth periphery, a longitudinal axis greater than the transverse and a symmetrical outlet. In the abnormal bladder, there is irregularity of the periphery, evidence of trabeculation and asymmetry or globular outline. The bladder is partly an abdominal organ until 10 years when it

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RETROGRADE UROGRAPHY / Tankesley

settles into the pelvis. Before that time, there is a relative disproportion between the bony pelvis and the bladder, which makes the bladder appear distended.

Case 1

Two-year-old white female had a history of repeated attacks of pyuria and dysuria. Cystoscopy showed a bladder neck obstruction and cystitis at the trigone. The ureteral orifices appeared to be normal. However, on cystography there was reflux of contrast medium into the right upper urinary tract. At operation, dense fibrosis was found in the bladder neck. Plastic repair was done.

Case 2

Two-year-old white female had a history of urinary frequency and dysuria for seven months. Pyuria failed to respond to repeated treatments. Cystoscopy showed chronic cystitis, especially in the vesical neck. The left ureterovesical junction was incompetent; the right was normal. Cystography showed a contracted bladder, reflux into the left upper urinary tract with moderate hydronephrosis and hydroureter. Cystostomy and left ureterovesical neostomy was done.

Case 3

Two-year-old white female had a history of chronic pyuria and dysuria. Cystoscopy, cystogra-

phy, and retrograde urography showed reduplication of the left upper urinary tract. One ureterovesical junction was in normal position, but was incompetent. The other ureterovesical junction was ectopic in floor of the bladder and entered a large ureterocele. Both left tracts showed hydronephrosis and hydroureter. The ureterocele was removed and ureterovesical neostomy was done.

St. Martin³ states that the ureterovesical junction acts in three ways to prevent reflux. The ureter enters the bladder obliquely so that there is an oblique intramural segment. This anatomy has an important physiological function. As the bladder pressure rises, there is (1) compression of the intravesical ureter, (2) pulling down of the ureter by the contraction of the trigone, thus increasing the length of the intravesical segment, and (3) contraction of the muscle of the intravesical ureter. Pressure studies by Melick show that this junction acts as a valve against bladder pressure, preventing reflux in the upper urinary tract. Bladder pressure may rise to 40 mm. Hg. on voiding. The intramural pressure is correspondingly high, while the ureteral pressure is five to 15 mm. The ureterovesical junction may also act as a valve to allow ureteral pressure and peristalsis. Incompetence of the ureterovesical junction allows reflux and inability of the ureter to produce peristaltic pressures. Dilatation of the upper urinary tract may be due to, (1) a hypertonic bladder, as in bladder neck obstruction or neurogenic bladder and (2) infection. Pressure in a dilated upper urinary tract, due to in-



Figure 1: Retrograde Urography.

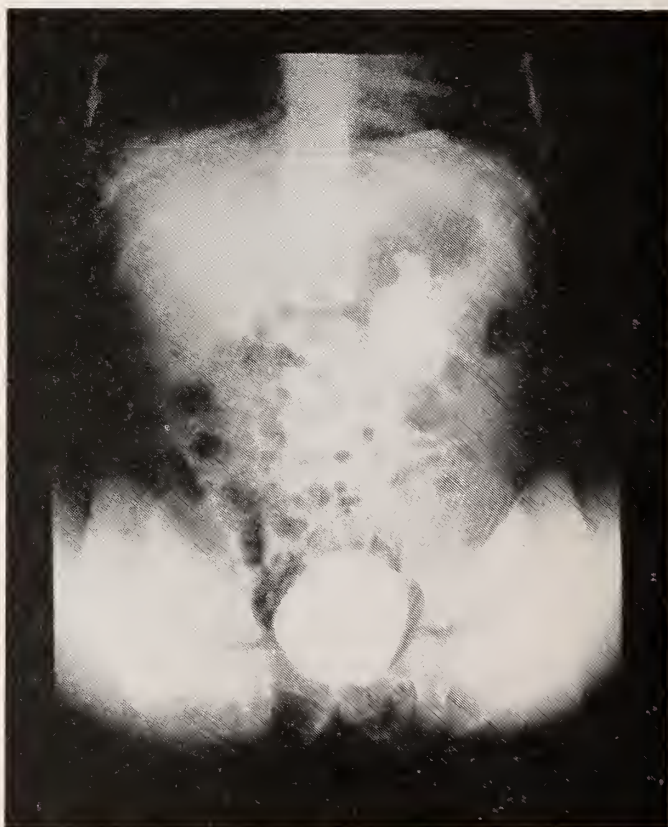


Figure 2: Retrograde Urography.



Figure 3: Retrograde Urography.

fection, is less than normal and this lack of ureteral pressure may contribute to non-functioning of the valve. Inherent defect in the ureterovesical junction is a possibility, but less likely.

McGovern⁵ states that all reflux is abnormal. Surgical correction is desirable, unless the damage

is irreparable. Correction of reflux may not restore the urinary tract, however. Surgery is suggested as follows: (1) nephrostomy, (2) correction of ureteral obstructions, (3) tunnel and cuff reimplantation of the ureter in the bladder, and (4) Y. or V. revision of the vesical outlet. The lower ureter is reimplanted obliquely through the bladder wall, forming a new ureterovesical junction. Leuzinger states that some cases of reflux can be corrected by non-operative methods by relieving points of obstruction by catheter. Relief of bladder pressure by plastic operation or by catheter frequently allows the dilated upper urinary tract to return to normal.

Conclusion

Urinary tract pathology and the usually associated infection is frequently the source of symptoms in infants and children. This pathology may or may not be identified on routine intravenous urography. Retrograde studies may demonstrate pathology which cannot be visualized otherwise. The voiding cystogram is especially helpful in fully evaluating the urinary tract.

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"BLUE SHIELD STUDY COMMISSION" ESTABLISHED

ESTABLISHMENT OF A "Blue Shield Study Commission" has been announced by the National Association of Blue Shield Plans, to undertake a major study of the "differences of concept and coverage" among the nation's 75 Blue Shield Plans which "have resulted in different approaches to the problem of providing adequate protection to the public."

In announcing the appointment of this new Commission, Dr. Donald Stubbs, Chairman of the Board of the National Association, pointed out that while the setting up of this Commission was directed by the Annual Conference of Blue Shield Plans in Los Angeles in April, its area of study and recommendation is logically related to the action of the A.M.A. House of Delegates in Miami on June 15, in reiterating A.M.A. support of the Blue Shield Concept and providing for strengthened liaison between A.M.A. and Blue Shield Plans.

"The job of this new Blue Shield Study Commission," said Dr. Stubbs, "is to identify and pinpoint the specific problems that must be solved and the needs that must

be met within Blue Shield if it is to be able to extend the broadest possible medical prepayment protection, under medical auspices, to the greatest possible number of people, and thus make the maximum contribution both to the public welfare and to the free practice of medicine."

Chairman of the nine-man Commission is Dr. Henry S. Blake of Topeka, Kansas.

Three of its members are the A.M.A. representatives on the Board of Directors of the National Blue Shield Association: Drs. David B. Allman of Atlantic City, N. J.; George M. Fister of Ogden, Utah, and Dwight H. Murray of Napa, Calif. Other members are Dr. Carl R. Ackerman of New York City, Board Chairman of the New York City Blue Shield Plan; Dr. A. A. Morrison of Ventura, Calif.; Dr. Donald N. Sweeney of Detroit, Mich.; Mr. Lewis G. Hersey, Executive Director of the Medical Service Bureau (Blue Shield Plan) of the Utah State Medical Association, and Mr. Walter R. McBee, Executive Director of the Texas Blue Shield-Blue Cross Plans.

DIABETIC NEUROPATHY

*The rapid reversibility of diabetic neuropathy and its occurrence
in relatively young persons militate against arterial
disease as the primary factor.*

Harry H. Brill, M.D., *Columbus*

DIABETIC NEUROPATHY IS an important clinical entity that deserves the attention of all physicians treating diabetes. Not a small part of the problem is the fact that neuropathy may present itself as a puzzling clinical syndrome that seems to defy diagnosis. The correct diagnosis may be overlooked or delayed if the clinical features of diabetic neuropathy are not familiar. Furthermore, certain diabetics seem more susceptible and deserve a careful neurologic evaluation. Correct diagnosis seems particularly urgent, since unlike retinal and kidney complications, the neuropathy usually improves rapidly under careful diabetic control. Delay in diagnosis may result in a painful disabling illness and increase the chances of permanent disability.

Historically, practically all of the symptoms of diabetic neuropathy were recognized and reported prior to the turn of the century. John Rollo (1798) described pain and paresthesia, particularly in the legs, as well as "lumbago and sciatica." Marcal de Calvi (1864) reported the common occurrence of sciatic pain and peripheral areas of anesthesia. The frequent absence of tendon reflexes in diabetics was recorded by Bouchard and Marinian (1884). Pryce (1887, 1893) described atrophy of the skin, trophic ulcers, and the presence of ataxia. Auché (1890) observed that the changes in the nerves did not run parallel with the sugar content of the blood or urine. In the first decade of the 20th Century, Williamson investigated the pathology and noted the frequent loss of vibratory sense. Thus, this neurologic complication of diabetes had been clearly described over 50 years ago¹. Many of the details have been further classified in recent monographs^{2,3}.

The incidence of this complication of diabetes has

varied widely in different reports³. Undoubtedly, the diagnostic criteria must have differed sharply to account for such variations. The 125 cases reviewed by Rundles in 1945 were gleaned from 3,000 diabetics, giving an incidence of five per cent. In some series, variation in the incidence may be only a quantitative difference depending on the exact criteria used by the reviewing physicians. Minimal reduction of vibratory sense, as used by Collens, may account for his high incidence of 93 per cent. Taking Rundles' very conservative figure of 5 per cent, we can say that the physician who does not recognize diabetic neuropathy in at least one out of every 20 diabetics is either overlooking the diagnosis or enjoys a remarkably well regulated diabetic clientele. Furthermore, neuropathy often makes its appearance prior to the diabetes. Pomeranze reported 10 per cent of his 1,000 cases with peripheral neuropathy as the earliest sign of diabetes⁴.

Case Reports

In order to characterize some of the neurologic syndromes, several cases are presented.

Case I: L. I., a 62-year old white housewife, was seen for the first time on May 15, 1959, complaining of leg pain. While there had been intermittent episodes of pain for a period of five years, her symptoms did not become troublesome until one year ago. She described deep aching pains in her feet, legs, and thighs, which were particularly severe in the right lower extremity. There were episodes of lightning pain on the right, beginning at the buttock and radiating down to the foot. Standing and walking did not aggravate her pain and sometimes even seemed to give relief. Pain was more severe at night. The toes of the right foot were numb and the calves of both

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legs seemed smaller. In the past year, she sought chiropractic adjustments without relief. Diathermy administered by a physician was of no avail. In 1958, because of loss of appetite, another physician referred the patient for a barium meal which proved normal. Thirst and nocturia have been excessive for three years. Her mother was diabetic and died at the age of 68.

On physical examination weight was 160 pounds; blood pressure was 170/110 mm. Hg., and the pulse 70 per minute and regular. The patient was well developed, obese, and showed obvious signs of discomfort. The pupils were equal and reacted to light. There was a right pterygium and bilateral arcus senilis. Fundi showed narrowing of arteries, but no hemorrhages or aneurysms. The skin of the lower third of both legs was bronzed. Chest and breasts were negative. The left cardiac margin was percussed four and a half inches to the left of the mid-sternal line in the fifth intercostal space. There was a low mid-line abdominal scar. First degree cystocele and atrophy of the cervix were present. Pulsations were vigorous in the dorsalis pedis and posterior tibial arteries of both feet. Patella reflexes were active bilaterally but neither Achilles reflex could be obtained. The distal portion of the right foot exhibited hyperesthesia to pin-prick.

Sigmoidoscopy was negative. Electrocardiogram revealed right bundle branch block. The chest x-ray was negative. X-ray of the cervical spine revealed osteophytosis and encroachment on intervertebral foramina.

Laboratory studies showed white blood count of 4,700 cells per cu. mm., hemoglobin 11.7 grams per cent, 48 neutrophils, 48 lymphocytes, one non-filamented neutrophil, one eosinophil, and two monocytes per 100 cells. The urine was straw colored, clear, and acid in reaction. The specific gravity was 1.026. There was no albumin; the urine showed 4+ glucose. Microscopic examination of the urinary sediment was negative. The blood glucose (Nelson-Somogyi) was 386 mgm. per cent two and one half hours after 100 grams of glucose. Blood urea nitrogen was 10 mgm. per cent. The serologic test for syphilis was negative. The following diagnoses were made: (1) diabetes mellitus, (2) diabetic neuropathy, (3) arterial hypertension, (4) arteriosclerotic heart disease manifested by right bundle branch block, (5) osteoarthritis of the cervical spine, and (6) cystocele.

The treatment program included 1,200 calorie diet, Lente insulin 15 units daily, therapeutic multivitamin capsule daily, and vitamin B-complex injections. On this regimen she showed a gradual weight reduction to 132½ pounds by September 4, 1959. Postprandial blood glucose also fell as follows: 152

mgm. per cent on June 17, 148 mgm. per cent on July 20, and 142 mgm. per cent on September 21. There was rapid and gratifying improvement in leg pain with disappearance of lightning pains.

Comment

This case demonstrates the delay that may occur in the diagnosis when neuropathy is the presenting symptom. The case is unusual considering the long period of five years that neuropathic symptoms were present before diagnosis. The rapid regression of symptoms under good diabetic control is typical. It may be possible to manage her diabetes with diet alone in the near future.

Case II: W. W. (Medical Center 51118A) is a 45-year old policeman first seen on August 30, 1954, with chief complaint of severe pain in both feet and legs. He complained of marked tenderness and hypersensitivity of the feet, associated with burning and tingling. He sought relief by sleeping with his feet out of the blankets. He described the sensation in the soles of his feet as feeling as though he were walking on thick crepe sole shoes. The symptoms had spread proximally in both legs and weakness of the muscles had developed recently. Impotence appeared at the same time as leg pain. The neuritic symptoms in the lower extremities had made their appearance two months earlier, leading W.W. to consult a physician who discovered glycosuria, a blood sugar of 211 mgm. per cent, and instituted diabetic treatment with insulin and diet.

Review of hospital records revealed an admission on June 29, 1954 with diagnosis of (1) diabetes mellitus and (2) low back pain and leg pain, undiagnosed. X-ray of the lumbar spine was negative and the patient was placed in leg traction over his violent protests. He refused an offer of psychiatric treatment and was dismissed. He was given injections of thiamin and vitamin B-12 without relief.

In July, 1954, he consulted a naturopath who discontinued insulin and prescribed a diet of grape juice. With this regimen, symptoms worsened rapidly. The burning extended from feet to knees and both legs became weaker.

On physical examination the blood pressure was 120/90 mm. Hg. Pupils reacted sluggishly to light. There was extreme hyperesthesia below the knees so that light touch was unbearable. Achilles and patella tendon reflexes were present bilaterally. Dorsalis pedis and posterior tibial pulsations were vigorous in both feet.

Laboratory studies showed hemoglobin 12 grams per cent and a white blood count of 15,750 cells per cu. mm. The differential count was 68 segmented neutrophils, 26 lymphocytes, four monocytes, and two eosinophils per 100 cells. Urine contained 35-50

DIABETIC NEUROPATHY / Brill

white cells per high power field in the centrifuged sediment and was negative for both albumin and sugar. Prostatic secretions showed innumerable pus cells. The serologic test for syphilis was negative. Lumbar puncture produced five ml. of clear colorless spinal fluid; there were no cells; protein was 151 mgm. per cent, and spinal fluid Kahn was negative. Postprandial blood sugar on September 3, 1954, was 148 mgm. per cent. The diagnoses were as follows: (1) diabetes mellitus, poorly regulated, (2) diabetic neuropathy, and (3) prostatitis. The treatment program included 1,800 calorie diabetic diet, multivitamins, sulfonamide for prostatic infection, and injections of denatured proteolytic enzyme for severe pain. Insulin was not necessary. By September 18, 1954, all pain had disappeared; hyperesthesia was less troublesome and confined to the feet. He was able to return to work in October, but convalescence was complicated by a psychotic episode. By April, 1955, he had mild residual tingling and burning of the feet, but was working regularly and symptoms were so mild that he felt no incapacity. Sexual potency had returned under dietary treatment.

Comment

This case again emphasizes the lack of correlation between the severity of the diabetes and the severity of the neuropathy symptoms. On the other hand, the neuropathy did correlate well with the degree of diabetic neglect. There was significant involvement of autonomic fibers manifested by impotence. The elevated spinal fluid protein and the rapid improvement under treatment typify diabetic neuropathy.

Case III: O. C., a 29-year old white policeman, was first seen on July 24, 1959, for diabetic supervision. His illness had its onset in the summer of 1958 with difficulty in emptying his bladder and impotence manifested by failure of erection. He had had intercourse one time in six months. There was a sense of loss of urinary force and difficulty in initiating the urinary stream. Review of past history revealed that in February, 1959, he consulted an urologist for these symptoms and was placed on Cytomel® and Glukor®. A few days later, glycosuria was discovered and he was referred to another physician who obtained a glucose tolerance test with the following results: fasting 126 mm. per cent, 30 minutes 182 mgm. per cent, one hour 220 mgm. per cent, two hours 182 mgm. per cent, and three hours 97 mgm. per cent. The urine was positive for sugar at the end of the first and second hours. He weighed 204½ pounds and was outwardly well. Diabetic diet and Orinase® resulted in an eight pound weight

loss and reasonably good diabetic control. In June, his fasting blood sugar was 107 mgm. per cent.

When first seen in this office on July 24, 1959, his blood pressure was 100/70 mm. Hg. sitting, rising 10 points systolic in the standing position. Pupils reacted to light and fundi were normal. Rectal sphincter tone was good and sensation and tendon reflexes in the lower extremities were intact. The white count was 7,700 cells per cu. ml., hemoglobin 15.1 grams per cent, 51 segmented neutrophils, 48 lymphocytes, and one monocyte per 100 cells. Hematocrit was 46 ml. per 100 ml. The specific gravity of the urine was 1.020. There was no albumin or sugar; microscopic examination of centrifuged sediment revealed 4-6 white cells per high power field. Serologic test for syphilis was negative. The two and a half hour postprandial blood glucose was 73 mgm. per cent (Somogyi-Nelson).

On a 2,600 calorie diet, his weight dropped to 188½ pounds, and symptoms subsided completely. By September 1, 1959, the patient reported normal urinary function and sexual intercourse three times a week.

Comment

This case again exhibits the occurrence of neuropathy in a mild diabetic. It also emphasizes the predilection for autonomic nerve fibers which in this instance innervated the bladder and genital area. And lastly, it indicates the good response when diabetic control is achieved.

Case IV: S. C. (Medical Center No. 44632, Dr. John Davidson) This 63-year-old white female was admitted to the hospital on January 4, 1955, because of episodes of syncope. The intern's record gives the following information:

"This 63-year old WF went to see Dr. Davidson in March, 1955, for hypertension in the realm of 260 according to daughter. Patient was put on Serpasil® which has reduced blood pressure considerably, in fact, to the point that the patient slumps down whenever she attempts to stand. She can usually walk about five steps before this occurs. After lying down for a few minutes she regains full consciousness. This is probably a side effect of Serpasil®."

A review of previous records revealed an admission September 24, 1953, for bilateral maxillary and ethmoid sinusitis. There was a second admission on March 15, 1954, for hoarseness. Laryngoscopy revealed a fixed left cord; this left recurrent laryngeal nerve paralysis was unexplained. Her third admission on November 17, 1954, was for influenza. All three admission urinalyses were negative for glucose.

Physical examination revealed blood pressure 180/100 mm. Hg. in the supine position; standing blood pressure was unobtainable. The left pupil was

smaller than the right. There was moderate cardiac enlargement to the left. Hemogram was normal. Admission urinalysis revealed specific gravity of 1.020 and no sugar or albumin. There were two glucose tolerance tests. The first on January 5, 1955 was done with the patient on a carbohydrate-poor diet: fasting 106 mgm. per cent, one hour 211 mgm. per cent, two hours 162 mgm. per cent, and three hours 122 mgm. per cent. The second test on January 10, 1955, showed fasting blood sugar 112 mgm. per cent, one hour 244 mgm. per cent, two hours 267 mgm. per cent, three hours 170 mgm. per cent. All urine specimens collected during both glucose tolerance tests were negative for sugar. Cerebrospinal fluid was clear and colorless; it contained two lymphocytes, 250 mgm. of protein, and showed negative Kahn. She was dismissed on a diabetic diet and parendrine and Neo-synephrin® for control of orthostatic hypotension.

Comment

This case exemplifies many of the problems of diabetic neuropathy and some of its typical features. Firstly, it presented as a diagnostic problem. The diabetes was mild so that the patient exhibited none of the classic symptoms. The renal threshold was high so that recognition awaited blood sugar reports. The diabetes was so mild that the diagnosis would have been missed on a single fasting blood glucose. In fact, neuropathic symptoms were the only diabetic manifestation. The orthostatic hypotension is due to involvement of autonomic fibers. The irregularity of the pupils is compatible. The recurrent laryngeal nerve palsy is presumably on a diabetic basis. The high spinal fluid protein is typical. Serpasil® probably played an unimportant role in her illness.

While this neurologic problem may be the presenting symptom of unsuspected diabetes, it may also be encountered in a number of situations, a knowledge of which will aid in recognition: (1) in poorly controlled diabetes, (2) in patients recovering from diabetic coma, (3) in those undergoing treatment for the first time, (4) patients with ischemia affecting the extremities, and (5) mild diabetics or new cases in whom metabolic control has been easily maintained⁵.

Search for Neuropathy

Neuropathy should be searched for in any poorly controlled diabetic. Its development should be watched for by investigating the symptoms and physical findings during convalescence from coma. It may prove a real challenge if it develops after the initiation of treatment. Needless to say, its appearance then will be disturbing to both physician and patient, but it should not deter the physician from pursuing careful diabetic control. This

occurrence was at one time incorrectly described as insulin neuritis. However, it has since been recognized that the neuropathy may make its appearance with the institution of either diet and insulin or with diet alone, and that insulin is not a causative factor. Sensory disturbances often supply the first clue to the diagnosis. Where ischemia of the lower limbs exists it is difficult to tell just how much of the pain is due to ischemic neuropathy and how much is purely diabetic. Neuropathy occurs with severe atherosclerotic vascular disease even in the absence of diabetes. The mild diabetic will provide the greatest challenge as it is in this group that most of the puzzling neurologic problems make their appearance.

Pain, tenderness, and paresthesia are the most frequent symptoms. The symptoms may involve only the feet or the entire leg. The lower extremities are most commonly involved. The patient may describe the symptoms as a numbness, tingling, coldness, crawling sensation, or prickling. The symptoms are apt to be worse at night and the patient may complain of having to place his feet from under the covers because of burning. Unlike the pain of ischemia, the pain of neuropathy is often reported as lessened by walking and activity. Hyperesthesia is commonly present and light touch or the bedclothes may be almost unbearable. Another description of the paresthesia is the feeling that there is sand in the shoe, or that the patient is walking on thick soles. In the area of sensation the test for vibratory sense may provide a helpful clue. Various authors have described impairment of vibratory sense in a high percentage of patients with diabetic neuropathy. Quantitative tests have been devised to give more accurate estimations of improvement. It is of some importance to note that vibratory sense is lost in a certain percentage of normal elderly people past the age of 50 who do not have other evidences of neuropathy.

Motor Disturbances Rare

Motor disturbances, such as muscle weakness, paralysis, and atrophy are considered to be rare. When present, such motor disturbances are more likely to occur in the distal lower extremity producing foot drop and occasionally involving the quadriceps femoris muscle. There have been rare reports of even cranial nerve involvement. The reflexes may provide a useful clue as the Achilles and/or the patella reflex were absent in 50 per cent of the 261 cases reported by Goodman³. The Achilles reflex was the one most frequently affected and this reflex loss provided a useful objective test along with vibratory sense.

The lesion involving the autonomic nervous system in diabetes is perhaps one of the most interest-

ing and also the one most likely to result in a confusing clinical picture. If glycosuria is absent and the diabetes mild and unrecognized, the patient with predominant autonomic involvement may present in a multiplicity of fashions and the exact diagnosis may be a difficult one to reach. There may be orthostatic hypotension, gastrointestinal disturbances, bladder difficulties, sexual involvement with loss of erection and/or ejaculation, unexplained edema, tachycardia, diarrhea, and fecal incontinence. It would be a good rule to do a glucose tolerance test or a two and a half hour postprandial blood glucose in any puzzling neurologic syndrome.

Autonomic Disturbances

Autonomic disturbances in the extremities may present with edema, erythema, atrophy of the skin and subcutaneous tissue, and perforating ulcers of the feet. These ulcerations may occur in the absence of any vascular deficiency. It should not necessarily be assumed that ulceration in the diabetic is due to atheromatous obstruction of the arteries of the lower extremities. Cardiovascular disturbances are interesting and orthostatic hypotension and tachycardia have been frequently reported. These patients may complain of weakness and syncope on arising from the sitting to the standing position. This can be proved objectively by checking the blood pressure with the patient lying, sitting, and standing. A drop in the blood pressure of 30 mm. of mercury or more in changing from the supine to the upright position is indicative of postural hypotension. Gastrointestinal disturbances may be somewhat less frequent. These consist of gastric retention with nausea and loss of appetite, cramps and abdominal distention, and occasional vomiting after meals. Another interesting finding is neurogenic or nocturnal diarrhea. This may consist of as many as ten stools a night occurring regularly or intermittently alternating with periods of constipation. Since the sympathetic nerves inhibit the colon, it is likely that this disturbance of gastrointestinal motility is the result of impairment of the function of the sympathetic nervous system. Bladder and sphincter disturbances manifest themselves as difficulty in urination, hesitancy or slow, weak urinary stream, and acute urinary retention. An earlier symptom is the difficulty in emptying the bladder, or a sensation of incomplete emptying and sometimes incontinence. Cystometric examination may show impairment or absence of a sense of filling or low expulsive force along with an increased bladder capacity. Impotence was reported in about 25 per cent of Rundles' patients with diabetic neuropathy².

There may be a loss of erection or ejaculation or both functions. Trophic skin lesions and perforating ulcers of the feet may appear suddenly. With proper attention to diabetic management and in the absence of occlusive arterial disease, these trophic lesions usually heal quickly and should be treated conservatively, avoiding amputation.

The neurogenic arthropathy or Charcot joint is a relatively rare complication, usually involving the ankle. The neuropathic foot as a rule is painless and many of the trophic signs may be present in the limbs including brittle toenails, dry scaly skin, and alterations in sweating.

While these symptoms and signs might be present in almost any neurologic disorder, there are certain characteristics which will help to distinguish diabetic neuropathies. Goodman³ has listed these features as follows: (1) a decided predominance of sensory symptoms, (2) extremely high incidence of absent reflexes in the lower extremities, particularly the Achilles, (3) frequency of disturbances of the autonomic nerves, and (4) the existence of specific treatment.

The spinal fluid may be of some help in diagnosis. While it can be normal, it frequently will show the single abnormality of a high spinal fluid protein. Joslin⁶ reports that the protein was elevated in 75 per cent of 157 patients. A fall in spinal fluid protein occurs with clinical improvement. Note should be made of the close resemblance of the spinal fluid findings to the Guillain-Barre syndrome or acute infectious polyneuritis. Recently, Ellenberg⁷ reported a diabetic who had been labeled as diabetic neuropathy and later proved to have typical infectious polyneuritis.

Pathogenesis Still Not Proved

The pathogenesis of diabetic neuropathy is still not proved. The concept of ischemia of the nerves due to vascular change has been discarded though ischemic neuropathy is well recognized and may occur in occlusive arterial disease even in the absence of diabetes. The rapid reversibility of diabetic neuropathy and its occurrence in relatively young persons militate against arterial disease being the factor. Vitamin deficiencies may coexist and occasionally complicate the neuropathy in diabetes. Again, most authors have ruled this out as being the sole factor because of the failure of neuropathy to respond to vitamins alone in the absence of good diabetic regulation⁸. True thiamin deficiency neuropathy yields promptly to specific vitamin therapy whereas diabetic neuropathy does not. Goodman feels that the cause lies in some obscure metabolic changes in nerve tissue incidental to uncontrolled diabetes. All

authors have seemed to agree that poor management and neglect of the diabetes and its consequent malnutrition are important factors and they all agree that it is one complication of diabetes which can be prevented or cured provided it is recognized and treated sufficiently early.

Objective Symptoms Often Outweighed

In the differential diagnosis there are certain cardinal factors to remember. The subjective symptoms of pain, paresthesia, and dysesthesia may far outweigh the objective findings in diabetic neuropathy. The absence of reflexes in the lower extremities is quite frequent and often the only objective evidence. In other types of peripheral neuropathy, absent reflexes are usually associated with motor involvement which is much less common and less severe in diabetic neuropathy. There are certain well-known neurologic syndromes which may be confused with diabetic neuropathy. In syphilitic tabes, the loss of reflexes, perforating ulcer, Charcot joint, leg pain, sexual impotence, and Argyll Robertson pupil present a problem along with the fact that tabetics often have negative serology and spinal fluid. The hyperesthesia of the legs in diabetic neuropathy is usually absent in tabes. The absence of pain on pinching the Achilles tendon and the loss of testicular sensitivity are not encountered in diabetes. Optic atrophy and crises rarely ever occur in diabetic neuropathy. In pernicious anemia the spinal cord involvement predominates over peripheral nerve involvement, the opposite from the changes seen in diabetes. The dissociation of sensation frequently seen in syringomyelia is not present in diabetes. In cord tumor, pain is usually unilateral and has the characteristics of root pain, whereas diabetic neuropathy is often bilateral and involves the distal extremities; later, the cord pressure produces long-tract signs which hardly ever occur in diabetes. Herniated disk is almost always unilateral and involves the sciatic nerves. Lead neuropathy affects primarily the motor fibers, whereas in diabetes the sensory fibers are predominantly involved. Guillain-Barre syndrome is particularly interesting as it causes muscular, reflex, and sensory changes along with spinal fluid changes that resemble diabetic neuropathy. The speed of onset with Guillain-Barre syndrome, its rapid progression, and the disturbance of the whole lower motor neuron are important differential features. Goodman gives the most important differential as being the rapid response of diabetic neuropathy to specific treatment, i. e., to strict diabetic control.

A high index of suspicion for diabetic neuropathy may result in failure to recognize some other neurologic disorder. Not all nervous system disease in a

diabetic need be caused by diabetes. This was recently emphasized in a report of seven cases⁷. The following were missed: two patients with herniated disk, one case of senile osteoporosis with compression of the lumbar spine, one case of pyogenic infection of the lumbar spine, and Paget's disease with sarcomatous degeneration. Each of these produced lower extremity pain mistaken for the pain of diabetic neuropathy. In addition, non-tropical sprue was erroneously called diabetic diarrhea and Guillain-Barre syndrome was misdiagnosed. This stresses that diabetic neuropathy is to some extent a diagnosis by exclusion since there is no specific test for its recognition.

Basic Treatment Good Diabetic Management

The basic treatment of diabetic neuropathy is good diabetic management, with proper diabetic diet and insulin. I have not discovered a controlled series in which insulin has been replaced by oral hypoglycemic agents and therefore cannot advise their use. Case II (O. C.) improved on diet and on an oral hypoglycemic agent (Orinase®) but his diabetes was so mild that he would probably have responded equally well to diet alone. Sometimes larger doses of insulin may be necessary during the initial period of treatment since the long period of preceding neglect may have increased the insulin needs. The use of liver extract, B-12, thiamin, B-complex vitamins, BAL, have been reported as disappointing by most authors^{2,3,5}. Since nutritional deficiency may be a part of dietary and diabetic neglect, it is reasonable to prescribe multivitamins in newly discovered diabetic neuropathy, but prolonged administration is unnecessary. To become preoccupied with these substances as a substitute for good diabetic control would actually be harmful. Many authors report progression of the neuropathy while the patient was receiving large amounts of vitamin B-complex, B-12, and diet was neglected.^{2,3,5}

Control of Pain

For control of pain it may be necessary to institute bed rest, a cradle over the legs, and warm baths. Great caution must be exercised not to raise temperatures with heat cradles or use baths too warm, particularly if there is an accompanying ischemia. Ordinary analgesics are ineffective in controlling pain. At times codeine may be necessary but morphine and meperidine should be avoided because of the risk of addiction. Goodman, et al,³ report the successful use of .25 per cent procaine solution intravenously to reduce pain. Appropriate splints and braces should be used for paralyses. The diabetic bladder requires treatment directed toward urinary retention and infection.

DIABETIC NEUROPATHY / Brill

Continuous bladder drainage and appropriate antibiotic may be effective. In other instances, surgical resection of the bladder neck may be necessary. Perforating ulcers will heal promptly with diabetic control and appropriate local measures. Again, the heat cradle with the thermostatically controlled temperature around 90° has been advised but should be avoided, if there is any occlusive vascular disease.

Summary

Diabetic neuropathy presents the clinician the following problems. Firstly, it may present as a puzzling diagnostic problem in which diabetes is unsuspected. Secondly, certain classes of diabetics seem more susceptible—newly discovered cases often with mild diabetes, diabetics recovering from coma, and poorly regulated diabetics. It would be a good rule of thumb to check a two and a half hour postprandial blood sugar or a glucose tolerance test in working up any patient with a vague neurologic disorder. Susceptible diabetics deserve a careful history with the questions

directed toward the following: pain, burning, tingling and numbness of the feet and legs, sexual potency, bladder function, nocturnal diarrhea, nausea and anorexia, dizziness or syncope with standing. Physical examination should include recumbent and standing blood pressure, evaluation for hyperesthesia of the legs, pin-prick perception, vibratory sense and tendon reflexes, particularly in the lower extremities.

313 Doctors Building

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PROJECTED PROGRAM FOR WARM SPRINGS FOUNDATION

PRELIMINARY STEPS IN a projected program to convert the famed Georgia Warm Springs Foundation into a general vocational rehabilitation center serving the southeastern United States were announced recently.

Founded more than 30 years ago by the late Franklin D. Roosevelt, Warm Springs has helped thousands of severely stricken polio victims to regain maximum use of their crippled bodies and to become useful citizens once again.

With the decline in polio that has followed the advent of the Salk vaccine five years ago, Warm Springs has begun to utilize its vast rehabilitation facilities to care for physical handicaps caused by arthritis, birth defects, spinal cord lesions, cerebral vascular accidents, multiple sclerosis, and other disabling neuromuscular disorders.

From the Warm Springs Foundation there grew, in 1938, the National Foundation for Infantile Paralysis, now known as The National Foundation. For more than 20 years the March of Dimes, through its county chapters across the nation, has been the principal support of Warm Springs. The National Foundation also has expanded its program beyond polio, with a substantial beginning already made toward prevention of birth defects and arthritis. Although now in new fields, The National Foundation continues to serve its original purpose of offering assistance to victims of paralytic polio.

Miss Mary Switzer, director of the Office of Vocational Rehabilitation of the U. S. Department of Health, Education, and Welfare, recently announced a special

grant of \$26,228 to the Georgia Warm Springs Foundation.

In announcing the award, Miss Switzer said:

"The grant is for the purpose of conducting a study to determine the possibility of developing the Georgia Warm Springs Foundation into a regional comprehensive rehabilitation center to serve the physically handicapped in the seven southeastern states."

Under the grant, Dr. Robert L. Bennett, executive director of the foundation, assisted by George C. Beckman, Jr., administrator of medical operations, will direct an evaluation of services presently available to the physically handicapped at the Warm Springs center.

As part of the project, it is planned that selected patients will be referred to the center by the various divisions of vocational rehabilitation in the southeastern states. This demonstration phase of the project is designed to provide valuable information on the need to expand and supplement existing services at Warm Springs to better care for patients disabled from causes other than polio.

There still are thousands of polio victims stricken in past years who will need rehabilitation and care for many years to come, Dr. Bennett pointed out. Also, new cases are still occurring and will continue to occur until polio is finally stamped out, he said.

"Facilities developed to care for polio patients are readily convertible to treatment of persons with physical handicaps from a wide variety of other causes. For several years we have been accepting non-polio patients and this will grow rapidly in the future."

SURGICAL TREATMENT OF CONGENITAL HEART DISEASE IN INFANCY AND CHILDHOOD

Robert G. Ellison, M.D.; David P. Hall, M.D.;
William E. Laupus, M.D., and A. Calhoun Witham, M.D., *Augusta*

An aggressive approach in diagnosis and surgical treatment must be maintained in order to salvage these infants for a useful life.

IN VIEW OF THE current and continued rapid advances in techniques of cardiac surgery, an appraisal of the problem of congenital heart disease in Georgia seems worthwhile. It has been estimated that 75 per cent of infants with congenital heart disease have operable lesions. More than 60 per cent of these babies with congenital heart disease will die within the first year of life,¹ usually from hypoxia or heart failure. Although medical management may help some infants, the chances of long survival without surgery are poor in those with serious symptoms within the first year of life. Accurate diagnosis and surgical treatment, therefore, are urgent. In some cases the surgical procedures are corrective, but frequently palliative operations are performed, to promote survival and to obtain growth to the age and size when complete correction of the defects with the use of the heart lung machine can be accomplished.²

The true incidence of congenital heart disease in Georgia is difficult to compute, but an estimate can be derived from certain available information. It has been estimated that each year in the United States 30,000 to 50,000 babies are born with congenital heart disease. If this number is reduced to the population of Georgia, 700 to 1,200 infants with congenital heart disease would be born each year in the state. Perhaps a more accurate estimate would be

based upon the number of cases of congenital heart disease per 1,000 live births each year. MacMahon,¹ in Birmingham, England, reported an incidence of 3.2 infants with congenital heart disease per 1,000 live births and McIntosh and associates³ found an incidence of six per 1,000 by following approximately 6,000 pregnancies at Presbyterian Hospital in New York City. Application of these rates to the approximately 100,000 live births in Georgia each year⁴ provides an incidence of 320 to 600 cases of congenital heart disease (Figure 1). The anticipated death of two-thirds of this group during the first year of life makes early diagnosis and surgical approach mandatory in order to salvage these critically ill infants.

Estimated Problem Congenital Heart Disease Georgia

Incidence

3-6 cases alive at one Mo. /1000 live births.
Total 300-600 cases/year.

Life Expectation

60% + (180-360) dead --- 1 year
30% or less (90-180) alive at -- 10 years

Figure 1.

Since the Talmadge Memorial Hospital opened in July 1956 through December 1959, 291 patients were discharged with the diagnosis of congenital heart disease, not including patients seen only in the Out-Patient Clinic. Eighty per cent of these patients had single defects or complexes such as tetralogy of Fallot, tricuspid atresia, etc. (Figure 2). The incidence of the various types of defects approximates that usually reported. Thirty-eight (13 per cent) of the 291 patients had combined defects, representing 22 different combinations of defects. Septal defects, pulmonary valvular stenosis, and patent ductus were

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CONGENITAL HEART DISEASE / Ellison

CONGENITAL HEART DISEASE (July '56 - Dec. '59)

Isolated Lesions - 233 Pts. 80% (291 Pts.)

	NO.	Per Cent
Ventricular Defects	48	16.5
Patent Ductus	46	16
Tetralogy of Fallot	36	12.4
Atrial Defects	26	9.0
Pulmonary Valvular Stenosis	18	6.2
Coarctation	14	4.8
Ostium Primum	10	3.4
Tricuspid Atresia	9	3.1
Aortic Stenosis	7	2.4
Transposition	5	1.7
Truncus	4	1.4
Infundibular Stenosis	3	1.0
Vascular Arch Anomalies	1	0.3
Other	5	1.8
	233	80%

Figure 2.

the most commonly encountered anomalies involved in these various combinations (Figure 3). Seventy (24 per cent) of the 291 patients were two years of age or under and this is the age group which we particularly wish to stress. Fifteen of the 38 patients with combined defects and 21 of the 54 cyanotic complexes were in the age group below two years of age. It is noted that in the infant age group, 52 per cent had complicated defects, whereas in the overall group only 32 per cent had complicated lesions (Figure 4). At the same time, it is noted that in the group under two years of age, only 36 per cent had single lesions, whereas in the overall group, 62 per cent had single lesions. These figures support the viewpoint that when an infant is in difficulty with congenital heart disease in the majority of case, he has a combination of lesions which is responsible for his getting into trouble at this early age. When a single lesion is responsible for serious symptoms, it most likely will be a ventricular septal defect or patent ductus (Figure 5). The majority of patients with cyanotic defects, such as the complexes listed, present themselves for treatment during the early years of life. Accurate diagnosis in this younger age group is difficult at best and errors in diagnosis and management necessarily occur. In these cases diagnosis was established by surgery, cardiac catheterization, or angiocardiology in the great majority of

IV CONGENITAL HEART DISEASE (July '56-Dec.'59)		
Combined Lesions-38 Pts. -13% (291 Pts.)		
38 Combined Defects		
22 Differant Combinations		
Atrial Septal Defects	24	Patients
Ventzicular Septal Defects	16	"
Pulmonary Valvular Stenosis	16	"
Patent Ductus	13	"
Anomalous Pulmonary Venous Drainage	8	"
Coarctation	6	"

Figure 3.

CONGENITAL HEART DISEASE		
Eugene Talmadge Memorial Hospital		
Admissions July '56 - Dec '59		
	Total Cases 291	Under Age 2 70
Single Defects	179 (61%)	25 (36%)
Combined Defects	38(13%)	15 (22%)
Complexes	54(19%)	21 (30%)
Undiagnosed	20(7%)	9 (12%)

Figure 4.

cases, and in a few it was felt that the diagnosis could be sufficiently established purely on the basis of clinical examination.

CONGENITAL HEART DISEASES		
ANALYSIS OF 70 CASES UNDER AGE 24%		
Single Defects (25 Patients)(36%)	Combined Defects (15 Patients)(21%)	Complexes (21 Patients)(30%)
Ventricular Septal 11	Ventricular Septal 4	Tricuspid Atresia 8
Patent Ductus 9	Patent Ductus 9	Tetralogy of Fallot 6
Coarctation 1	Coarctation 2	Transposition 4
Vascular Ring 1	Vascular Ring 1	Truncus 3
Anomalous Ven. Drainage 1	Anomalous Ven. Drainage 1	
Infundibular Stenosis 1	Pul. Valve Stenosis 3	
Ostium Primum 1	Ostium Secundum 11	
	Aortic Stenosis 1	

Figure 5.

Patent ductus arteriosus was the most commonly encountered lesion in the infant age group, occurring 18 times, nine as a single defect. Although the diagnosis of a patent ductus arteriosus may be quite easy, in the small infant with heart failure, pulmonary hypertension or when associated with other defects, such as ventricular defeat or atrial septal defect, the murmur is atypical and diagnosis difficult.^{5,6} If the baby is doing well clinically, diagnostic studies and/or surgery can be deferred and with further observations the diagnosis may become clarified. On the other hand, if symptoms are severe, diagnostic studies, such as cardiac catheterization and/or angiocardiology are urgent. On occasion we have preferred to proceed directly with surgical exploration without diagnostic studies, feeling that any procedure performed should be one that would lead to immediate improvement. The combination of patent ductus and ventricular septal defect is usually managed by simple division of the ductus, deferring closure of the septal defect for a later date.

Ventricular septal defect occurred in 15 patients under two years of age, 11 times as an isolated lesion. Some of these babies are in difficulty early in life, sometimes almost from the time of birth. Failure to gain weight, feeding difficulties, cough and respiratory distress are common symptoms presumably due to pulmonary congestion produced by the large left to right shunt.^{7,8} Ordinarily, if an infant is clinically well and has only minimal to moderate

cardiac enlargement, diagnostic studies are deferred until shortly before the expected age for surgical repair. The greater technical problems associated with use of the pump oxygenator in small children make it desirable to postpone surgery until the child reaches a weight of 8-10 kg. At this time the ventricular defect is closed by direct suture by open techniques with the heart-lung machine. When these babies cannot be controlled with the most strict medical means, a palliative surgical procedure, such as a modification of the Muller banding operation is utilized.⁹ In this procedure, pulmonary stenosis is created by narrowing the pulmonary artery until the pressure approaches normal beyond the stenosed area. Critically ill babies tolerate this procedure fairly well and usually immediate improvement follows as the result of reduction in pulmonary congestion. At a later date, a second operation under direct vision using the heart-lung machine can accomplish complete correction of both the congenital and acquired palliative defects.¹⁰

Cyanotic Type Lesion

Almost one-third of the patients seen under age two had a cyanotic type of congenital heart lesion. Tricuspid atresia was the most common of this group. Life expectancy of these infants probably is in the range of two to three years and most of these babies are in difficulty at the time they are first seen. Keith has reported about one-half are dead by the end of six months and only 10 per cent survived ten years.¹¹ The diagnosis is usually not difficult: cyanosis in an infant or child with ischemic lung fields and left ventricular enlargement is pathognomonic. As yet this defect cannot be completely corrected and the most common procedure is that of palliation by means of a systemic-pulmonary artery anastomosis.^{12,13,14} Recent experimental and clinical studies indicate that vena caval-pulmonary artery shunts may have considerable merit for these patients.^{15,16}

Tetralogy of Fallot was the next most commonly encountered cyanotic congenital heart lesion in infancy. At this age symptoms are chiefly due to hypoxia whereas later, in addition, difficulties arise as a result of thrombosis of cerebral vessels secondary to polycythemia. It is desirable to avoid surgery at this early age, if possible, in hopes that the child will survive until age four or five, at which time complete correction of the defects can be accomplished by open means utilizing the heart-lung machine.^{17,18} On the other hand, regardless of how young the baby is, if he is in serious difficulty from hypoxia, surgical exploration is performed sometimes as an emergency, with the establishment of a systemic-pulmonary artery anastomosis in order to improve pulmonary blood flow. When a shunting procedure

has to be performed, the Blalock-Taussig operation (subclavian-pulmonary artery) is preferred.^{12,13} On the other hand, if the left subclavian artery is not sufficiently large to utilize for the anastomosis, a Pott's (aorto-pulmonary artery) anastomosis is performed.¹⁴

Transposition Defects

Transposition of the great vessels was seen in only four instances in this group below age two. The prognosis in this group of babies is very poor, life expectancy being only a few months.^{11,19} For the most part, palliative procedures, carried out to improve mixing between the two circulations, offer the greatest help for these critically ill babies. The most commonly used operation is the Blalock-Hanlon extra-cardiac atrial septal defect associated with a shunting procedure in the event of associated pulmonary stenosis.²⁰ Attempts to completely correct transposition defects are still experimental and at this stage have not met with wide success.²¹

Truncus arteriosus occurred in three cases. Since this anomaly cannot be helped surgically it is of importance to differentiate it from those that are candidates for some surgical procedure. Angiocardiography often is of help in this regard. Occasionally, the differentiation between a truncus and tetralogy of Fallot cannot be established and surgical exploration is necessary since a shunting procedure would be performed, if the baby has a tetralogy of Fallot.

Pulmonary Stenosis

Pulmonary stenosis occurred in four cases, only once as an isolated lesion and this was of the infundibular variety. The greatest problem that arises in regard to this defect is the differentiation between pulmonary stenosis, usually with an associated atrial septal defect and tetralogy of Fallot.²² The tetralogy of Fallot is a more common lesion. In both cases the surgical procedure performed is palliative but the surgical exposure is different. In the case of pulmonary valvular stenosis ordinarily a transventricular (Brock) pulmonary valvulotomy is performed through an anterior thoracotomy or median sternotomy.²³ On the other hand, as previously stated, in the case of tetralogy of Fallot a shunting procedure is performed, usually through a posterolateral thoracotomy. Sometimes both cardiac catheterization and angiocardiography are necessary to establish the diagnosis. Right ventricular pressure in excess of systemic pressure is diagnostic of pulmonary stenosis with an intact ventricular septum. If pulmonary stenosis is asymptomatic in infancy, surgery can be deferred and the defects corrected by open methods later in childhood.^{24,25}

Coarctation of the aorta occurred in only three

instances, once as a single defect. Heart failure is usually the basic problem at this age. Usually, if coarctation occurs as an isolated defect, the patient's symptoms can be controlled and surgery may be deferred until the optimum age of ten years. The presence of an associated patent ductus arteriosus makes the prognosis worse, particularly if the coarctation is of the preductile variety,^{26,27} that is if the patent ductus communicates with the aorta distal to the coarctation. Mustard²⁷ found that in symptomatic babies over 60 per cent of the postductile type and 89 per cent of the preductile type will not survive unless treated surgically. If compensation cannot be promptly obtained or if patent ductus arteriosus is present, surgical resection should be performed without delay.^{2,28}

Atrial septal defect occurred 12 times in this group of 70 infants. The one case which occurred singly was an ostium primum anomaly. The secundum defect alone rarely produces symptoms in infancy but may contribute to serious symptoms when it occurs in combination with other defects. The ostium primum defect, however, presents a much more serious problem because of involvement of the mitral or tricuspid valves and often produces serious symptoms in the infant or young child. The ostium secundum defect can be repaired by open means with the pump oxygenator later on in childhood as an elective procedure. The ostium primum defect, however, occasionally presents such serious symptoms in infancy and early childhood that one is forced to go ahead with repair at this time. This anomaly be corrected only by open means utilizing the pump oxygenator. In view of the technical difficulties involved in reconstruction of the mitral valve, particularly in the infant, it is desirable to avoid surgery during this age period, if possible.²

Anomalies of Venous Return

Anomalies of venous return were recognized in only two cases. One of these was an isolated anomaly while the other occurred in combination with other defects. Anomalies of pulmonary venous return are not uncommon and are usually associated with secundum atrial septal defects and present no problem in surgical correction. Total anomalous venous return is a much more serious problem and few patients survive beyond infancy. Venous drainage is into the left superior vena cava, coronary sinus, right atrium, superior vena cava, or into infra diaphragmatic locations.^{11,29,30} The only help that can be offered these critically ill babies is complete correction utilizing the heart-lung machine.^{31,32}

Anomalies of the aortic arch occurred in two in-

stances, once as a single defect. These babies with vascular rings usually present a picture of tracheal obstruction soon after birth with progressive difficulty due to hypoxia and superimposed respiratory infection. The diagnosis can be confirmed usually with an esophagogram made by instillation of iodized oil into a catheter placed into the hypopharynx.³³ Division of the smaller arch can usually be performed through a left thoracotomy with immediate improvement in the respiratory status.^{34,35}

Congenital Aortic Stenosis

Congenital aortic stenosis occurred only once in these 70 cases and then was combined with other defects. Ordinarily, it is not considered a serious disease in infancy and in our experience is seen more commonly in a slightly older child. Severe symptoms in this age group, however, have been reported and the lethal nature of aortic stenosis is recognized in the fact that many children with this lesion will die suddenly, presumably from sudden myocardial ischemia.³⁶ In the absence of serious symptoms surgical intervention has been determined by the severity of left ventricular enlargement, determined by the electrocardiographic and roentgenological studies. When heart failure is present, however, direct aortic valvulotomy with the heart-lung machine is urgent.^{2,37}

In nine infants there was insufficient information for a diagnosis. Some of these babies possibly had endocardial fibroelastosis or anomalous origin of the left coronary artery. The prognosis in both lesions is quite poor, few patients surviving beyond two years of age. Palliative surgical procedures for both types of defects have been reported and perhaps are worthy of consideration.^{38,39,40}

Of the 291 cases of congenital heart disease admitted to the Eugene Talmadge Memorial Hospital during its first three and a half years of operation, 136 surgical procedures were performed upon 131 patients (Figure 6). Limitations upon hospital beds and operating room facilities necessarily restricted this program considerably during the first two years. More recently the gradual expansion of hospital facilities has permitted an increasing amount of con-

SURGERY IN CONGENITAL HEART DISEASE
EUGENE TALMADGE MEMORIAL HOSPITAL
July 1, 1956 — DEC. 31, 1959

	No.	Deaths	% Mortality
1. Total cases	136	20	14.7
2. Pump oxygenator	41	12	29.0
3. Non-pump cases	95	8	8.4
4. Palliative procedures in infants	26	5	19.0

Figure 6.

genital heart disease surgery. During the year July 1, 1958 to June 30, 1959, 48 per cent of the total thoracic surgery performed was of a cardiovascular nature and 30 per cent of all thoracic surgery was upon congenital heart disease. Selection for surgery has been determined by severity of symptoms and the more seriously ill patients have been given priority over those with minimal or no symptoms. All deaths have occurred in critically ill patients. Of the 12 deaths in the group undergoing open heart surgery with the pump oxygenator, two occurred early in our experience in very seriously ill patients whose deaths may have been contributed to by errors in our perfusion system. These mortality rates are in the same order as those usually published except in specially selected groups of cases. Twenty-seven of the 136 operations were upon infants under age two. Seven of these were for division of a patent ductus while the remainder were palliative operations for such defects as tetralogy of Fallot, tricuspid atresia, transposition of great vessels, and ventricular septal defect.

Summary and Conclusions

The incidence of congenital heart disease in Georgia has been estimated at 300 to 600 new cases born each year, almost two-thirds of whom die during the first year of life. Analysis of 291 cases admitted to the Eugene Talmadge Memorial Hospital during the first three and a half years of operation reveal that one-fourth were under age two. Over half of these infants had complicated defects. Ventricular septal defect and patent ductus arteriosus accounted for most of the single lesions in this group. Problems in diagnosis and surgical treatment in these babies were discussed. An aggressive approach to diagnosis and surgical treatment is emphasized in order to salvage these critically ill infants.

Medical College of Georgia

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POLITICAL CAMPAIGNS ON ISSUE OF HEALTH CARE FOR AGED

DEMOCRATS AND REPUBLICANS are campaigning on opposing planks on the issue of health care for the aged. The Democratic party advocates the Social Security approach; the Republican party favors federal aid in the field, but outside the Social Security system.

The GOP plank pledged:

"Development of a health program that will provide the aged needing it, on a sound fiscal basis and through a contributory system, protection against burdensome costs of health care. Such a program should:

"—Provide the beneficiaries with the option of purchasing private health insurance—a vital distinction between our approach and Democratic proposals in that it would encourage commercial carriers and voluntary insurance organizations to continue their efforts to develop sound coverage plans for the senior population.

"—Protect the personal relationship of patient and physician.

"—Include state participation."

The key paragraph of the Democratic plank stated:

"The most practicable way to provide health protection for older people is to use the contributory machinery of the Social Security system for insurance covering hospital bills and other high cost medical services. For those relatively few of our older people who have never been eligible for Social Security coverage, we shall provide corresponding benefits by appropriations from the general revenue."

Charles H. Percy, Chairman of the GOP Platform Committee, stated that the reference to a "contributory system" in the Republican plank did not mean a Social Security tax.

Presidential and Vice Presidential candidates of both parties went into the election campaigns pledged to support the health-care-for-the-aged planks adopted by their respective conventions. Vice President Richard M. Nixon, the GOP Presidential nominee, already was on record as unalterably opposed to any program of national compulsory health insurance. The long-established

position of Sen. John F. Kennedy of Massachusetts, the Democratic Presidential candidate, has been "that only by use of the Social Security system can we have true health insurance."

Speaking for the American Medical Association, Dr. Edward R. Annis of Miami, Fla., appeared before the platform-drafting committee of the Democratic convention at Los Angeles, and Dr. Leonard W. Larson, AMA President-elect, before the Republican policy group at Chicago.

The AMA spokesmen warned both parties that a program following the Social Security approach "would be unpredictably costly; it would unnecessarily cover millions of people; it would substitute service benefits for cash benefits; it would lead to poorer—not better—quality of medical care; it would overcrowd our hospitals; it would lead to the decline, if not demise, of private health insurance; and it would interfere dangerously with the doctor-patient relationship, which is the solid foundation upon which effective medicine must be based."

Dr. Annis also urged support of the House-approved Mills plan to provide health care for the needy aged who need help with the federal government and the states sharing the costs outside the Social Security mechanism.

In an advertisement run in some large daily newspapers in mid-August, the A. M. A. outlined its reasons for supporting the Mills plan, the ad said, in part:

"The A. M. A. believes our nation, as well as its senior citizens, will best be served by a locally administered health aid program designed to help those who need help. . . .

" . . . We are equally sincere in our opposition to legislative measures that approach the problem on a shotgun basis—with the idea of increasing repeatedly the Social Security tax in order to finance health benefits for *everyone* who is covered by the Old Age, Survivors and Disability Insurance program, regardless of their need."

THE IMMEDIATE TREATMENT OF MULTIPLE INJURIES OF THE LOWER EXTREMITIES

George J. Curry, M.D., *Flint, Michigan*

THE IMMEDIATE TREATMENT of multiple injuries involving the lower extremities demands expeditious application of common sound principles. Good, safe, quick, and intelligent transportation is mandatory. Appraisal and evaluation of the extent of injury without delay. The physiological status of the injured person must be a guide. Definitive care and immediate care of any injury really begins at the scene of the accident. Subsequent management has been called definitive treatment, but the whole story is a continuous process.

Lower extremities with multiple injuries may have soft or hard tissue involvement, alone or in combination. This includes skin, muscle, nerves, ligaments, blood vessels, and bone. Main blood vessel severance or destruction may produce loss of life, limb, or both. Damage to the other structures are repaired independently or in combination. This is obvious, and many times is associated with injuries to other parts of the body.

Summary

The immediate treatment of lower extremity injuries involves:

1. Good, careful, expeditious transportation. The injured deserve a safe ride to the hospital. Ambulances *do not* need to speed.
2. Immediate recognition of the sites, extent of damage, and general condition of the patient.
3. The management is one of both choice and necessity.
4. Delays are always inexcusable. "Procrastination is the thief of time."
5. Blood, blood, and more blood.
6. Assume a sensible and rational point of view that fits the case and then proceed with courage, confidence, and good common sense, recognizing the individual requirements directed toward the saving of life and limb.
7. A good experienced general surgeon with broad experience is preferred as a team captain.
8. Seek experienced help, if needed.
9. If none is available, do it alone, but *do it now!*

401-3 Genesee Bank Building

Presented at the *106th Annual Session of the Medical Association of Georgia, May 3, 1960, Columbus, Georgia.



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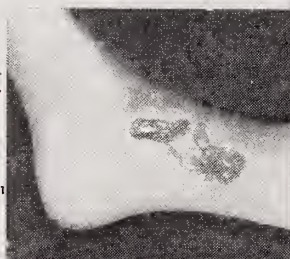
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*Heroic measures resulted in the survival and ultimate recovery
of this critically ill patient.*

William David Varner, M.D., *Columbus*

THIS 33-YEAR old colored Para 0-0-2-0 was seen for the first time in the emergency room on February 9, 1958, with complaint of excess vaginal bleeding and history of having had normal regular menses until scanty menses in January, 1958 and rather profuse vaginal bleeding for the past three weeks. She had onset of abdominal pain and fever on the day of admission.

Past History

Two spontaneous abortions were without complications; hospitalized in 1956 and again in 1957 with acute pelvic inflammatory disease, receiving three transfusions and antibiotics during last hospitalization.

General physical examination was essentially negative except slight distention and tenderness of the abdomen. On pelvic examination, the cervix was clean with old blood oozing from the external os. The pelvic organs were not definitely outlined due to tenderness. On February 10, 1958, a D and C and biopsy of the cervix was done. On examination the uterus could not be identified as such but was incorporated in a mass about 12 cm. in diameter which was irregular both in outline and in consistency, but generally firm. Pathology report of the tissue was "inactive polypoid endometrium with decidual change and subacute inflammation; chronic cervicitis and endocervicitis." White blood counts and differentials done postoperatively were reported

to be very suggestive of myelogenous leukemia because of the large number of immature white blood cells present. Bone marrow study was done on February 22, 1958, and revealed moderate hyperplasia of the bone marrow but with no evidence of leukemia. X-ray of the abdomen on February 13, 1958 was negative.

Her course in the hospital was that of gradual improvement with temperature spiking up to 101 degrees until the fifth postoperative day when it became normal and remained so. Achromycin® and Dicrysticin® were given during her hospitalization. She was discharged with a diagnosis of chronic pelvic inflammatory disease, leiomyoma uteri, secondary anemia, and probable septic abortion. However, there was no history of induced abortion of any type.

On March 17, 1958, she was readmitted for laparotomy. RBC was 4,000,000; urinalysis was negative, and temperature was 98.6 degrees. She was given one unit of blood preoperatively on the night of admission and on March 18, 1958, operation was done. On opening the peritoneal cavity, there was seen to be fine, filmy adhesions of the intestines to each other and to the parietal peritoneum throughout. The uterus was irregular, nodular, about four times normal size and there were two tubo-ovarian masses about 10 cm. in diameter which were adhered in the cul-de-sac to the rectal wall and to the peritoneum of the cul-de-sac. A complete hysterectomy, bilateral salpingo-oophorectomy, and appendectomy was done and the entire length of the intestines was explored and adhesions were freed.

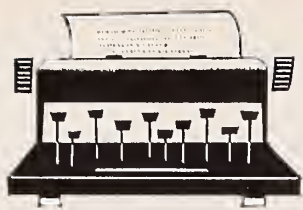
Presented at the *106th Annual Session of the Medical Association of Georgia, May 3, 1960, Columbus, Georgia.

The patient withstood the procedure well and received 500 c.c. of blood during the operation, with another 500 c.c. started when the operation was finished. She was started on Dicrysticin® postoperatively and otherwise routine postoperative orders. She had an uneventful course until the second postoperative day when she had an episode of epigastric discomfort with complaint of heart beating fast, but was found to be negative on examination except for a pulse of 125 and slight abdominal distention. However, the abdomen was soft and she was passing some flatus. On the third postoperative day, she received an enema with resulting stool. However, the abdomen was more distended and peristalsis was high pitched. Because of increasing abdominal pain and beginning nausea, a Levine tube was inserted during the night of the third postoperative day and she became much more comfortable and still continued to pass gas by rectum. An x-ray on the fourth postoperative day revealed a probable pelvic mass and some small bowel distention, but was a picture of adynamic ileus rather than mechanical obstruction. Rectal examination revealed a firm, tender mass which was more in the left pelvis and impinging somewhat on the rectal lumen and was thought to be inflammatory induration. At 1:45 A.M. on March 23, 1958, her fifth postoperative day, the patient was found to be cold, clammy, pulseless, without blood pressure, and complained of pain in her left chest. Mucous membranes were slightly pale, and she had very rapid heart rate and respirations. However, breath sounds were normal and no rales were heard. The abdomen was distended and no peristalsis was heard. Extremities were cold and the veins were collapsed. Oxygen was given; a cut-down was done, and blood was started. Levophed® was started I. V. and the usual shock procedures instituted. In about one hour, blood pressure reached 100/80 but the patient still appeared to be in shock. The urine had a port wine appearance and showed a one plus albumen. For the next few hours the patient appeared to be about the same, acutely ill but not becoming worse. X-ray revealed a profuse peritoneal density and mechanical obstruction of the small bowel. The left lung field showed a homogenous haze which was thought to be on the basis of a diffuse plural effusion. About 16 hours after the acute episode of shock, laparotomy was done with the original incision reopened and there was seen to be dilated loops of small bowel generally, covered with fibrinous exudate. Upon entering the cul-de-sac a large amount of serous, fecal-smelling fluid escaped and other pockets of foul-smelling fluid were broken into beneath the diaphragm on both sides and in scattered areas between loops of dilated gut. Exposure of the cecum revealed no evidence of breakdown

of the appendiceal stump or leakage from this area. Exploration of the small gut revealed no one area of obstruction, but a general massing together of the intestines by the exudate. Incision was made into one loop of small gut and a mushroom catheter was inserted and a pursestring suture was taken around this to prevent leakage. Stab incisions were made in both flanks and Penrose drains inserted into the lateral gutters and brought out through the abdominal wall. A hard rubber drain was placed in the cul-de-sac and this was brought out the lower portion of the incision. The abdomen was closed with through and through sutures with the catheter, which opened into the small gut, left closed and anchored to the anterior abdominal wall. Blood and other supportive procedures were given to the patient during this procedure and she left the operating room without any evidence of deterioration in general condition. Temperature spiked as high as 105.8 degrees postoperatively. She maintained blood pressure fairly well but was in very precarious condition, with fast pulse and respirations and poor urinary output with port wine urine. I. V. Terramycin® and Solu-Cortef® were started. When the report of the cultures taken from the peritoneal cavity was received, it was found that the organism was *Cl. welchii*, *E. coli*, and a non-hemolytic strep. The *Cl. welchii* culture was sensitive to Furadantin®, so I. V. Furadantin® was started in as large doses as were recommended. On the fourth day after the second laparotomy, the patient was having stools and the Levine tube was removed. On the fifth day after the second laparotomy, she had an episode of near coma and was found to have acidosis. She was hydrated and responded well. The drains from the flanks and the suprapubic drain were gradually removed, being completely removed on the 12th postoperative day. On the 16th postoperative day, the ileostomy tube was removed but fecal material was seen to be oozing from the sinus formed by the adhesion of the gut to the abdominal wall. On the 25th postoperative day, her temperature again began spiking up to 102° and there was seen to be more fecal drainage from the fistula. She was again started on antibiotics. Opaque media injected into the fistula revealed a bowel pattern of distal jejunum or possible ileum and a very short sinus tract. On the 36th postoperative day, excision of the fistula and a jejuno-jejunostomy was done. On the 46th postoperative day, patient was discharged after having been in the hospital for 52 days.

The patient was last seen on February 29, 1960 with no complaints except for some constipation and was found to be generally in good condition with the pelvis soft and no masses present.

Medical Arts Building



editorials

The World Situation And The Right To Vote

EVERY DAY IN the staff rooms and locker rooms of our hospitals we hear and participate in discussions centering about national and world affairs. The fact that so much time is given to these discussions is ample proof of the concern of the average doctor for the future of his country. In spite of our individual concern, though, most of our energies are consumed by these discussions without actually translating our opinions and ideas into action.

Traditionally, through the years the image of the doctor has been that of a strong individualist. We in the profession know this is still true for the most part. If strength and leadership were ever needed in the affairs of our country—they are needed today. While doctors by virtue of time limitations in their practice do not frequently seek public office, their influence in their individual communities is unquestioned.

No political party has a monopoly on the allegiance of the medical profession, and to contemplate such a situation is unthinkable. In these times it behooves each of us, as doctors and responsible citizens, to demonstrate our interest in good government within our individual communities. We must be recognized as a strong responsible group of citizens, if our voice is to be heard through the din of national and international politics. We must change

the recent false public image of the doctor from that of a rather passive individual in civic affairs to that of a strong aggressive fighter for the principles on which this country was founded.

It is the opinion of the writer that a great deal of good could be accomplished by the doctors of Georgia on November 8, if we could all agree to close our offices either for the entire day or for a designated period during that day. The purpose of such an observance of election day would make it possible for the physician, his aides, and his patients to go to the polls on this crucial day. Not only would closing of doctors' offices facilitate voting but it would point up for all to see the intense interest all doctors share in the future of our country.

Assurance would have to be given to patients that all their emergency needs would be served on this day. Scheduled operations could proceed without interruption. No patient need be neglected on this day. Suitable posters could be made available for display in doctors' offices outlining the election day schedule of closing.

Several doctors' groups have expressed interest in this observance of election day. It is hoped that the doctors of Georgia may consider such a plan of action at the local level.

G. A. G. P. Annual Session

THE GENERAL PRACTITIONERS of Georgia will meet in Atlanta October 12-13, 1960 at the 12th Annual Session of the Georgia Academy of General Practice. This outstanding meeting will be held at the Dinkler Plaza Hotel and is "must" in scientific postgraduate education. As in the past at this annual G.P. affair, the Academy will blend its business sessions with the fellowship of the profession.

Scientific papers presented at the session include every phase of general practice. Another highlight of the meeting is the President's Banquet at which time "night club" entertainment is scheduled to replace banquet speechmaking. A gala evening is promised to captivate the physicians and their wives.

The central location of the Headquarters, Hotel Dinkler Plaza, will provide the doctors' wives with ample opportunity to enjoy the shopping facilities of Atlanta.

It behooves every G.P. to attend this program for postgraduate education. The annual Academy meeting has always been one of the best attended meetings in the state and the 1960 session is no exception. Program invitations to attend this meeting will be mailed to the general practitioners in Georgia and G.P.'s are urged to participate. The date: October 12-13, 1960; the place: Dinkler Plaza Hotel, Atlanta; the time: good time well spent! Make your hotel reservation now and schedule this meeting on your calendar.

SPECIALTY SOCIETY CHAIRMEN MEET

PHYSICIANS REPRESENTING THE 17 specialty societies in Georgia met recently to program the Medical Association of Georgia 1961 Annual Session to be held May 7-10, at the Atlanta Biltmore Hotel.

So that the MAG scientific program will appeal to all MAG members, the representatives of the specialty societies actually make up the section meetings. In this way, each physician's interest is represented by his own specialty society. The proposed scientific program of section meetings and joint section meetings as set up by this group is tentatively scheduled as follows:

Sunday, May 7

2:30 P.M. to 5:30 P.M.

- (1) Orthopedic Section Meeting
- (2) EENT and Anesthesiology Joint Section Meeting
- (3) Pediatrics and Psychiatry Joint Section Meeting
- (4) Radiology Section Meeting
- (5) Pathology Section Meeting

Monday, May 8

9:00 A.M. to 12:00 NOON

- (1) Surgery, Anesthesiology, and Radiology Joint Section Meeting
- (2) Medicine, Diabetes, and Dermatology Joint Section Meeting
- (3) Urology, Obstetrics, and Gynecology Joint Section Meeting
- (4) Pediatrics and Psychiatry Joint Section Meeting

(5) Pathology Section Meeting

2:30 P.M. to 5:30 P.M.

- (1) Surgery and Urology Joint Section Meeting
- (2) Chest, Radiology, and Medicine Joint Section Meeting
- (3) Obstetrics and Gynecology Section Meeting
- (4) Pediatrics and Orthopedics Joint Section Meeting

Tuesday, May 9

9:00 A.M. to 5:00 P.M.

GP DAY (Scientific General Session)

Wednesday, May 10

9:30 A.M. to 5:30 P.M. (By special registration)

- (1) Medical-Legal Workshop

Also scheduled by MAG are the traditional general business sessions, sessions of the House of Delegates, and many social activities. The specialty societies, as at past MAG meetings, will hold their luncheons and dinners for their membership in conjunction with MAG.

First call for papers from Georgia physicians to present at the section meetings has been published in the *Journal of MAG* with the names of the section program chairmen for the forwarding of papers by physicians wishing to participate. MAG members are urged to participate and make the 1961 MAG Annual Session a meaningful meeting of Georgia medicine.

1961 Annual Session

May 7-10, 1961—Atlanta Biltmore Hotel, Atlanta, Ga.



Second Call for Scientific Papers

All titles must be submitted to the respective program chairmen listed below before November 1, 1960.

ANESTHESIOLOGY

John E. Steinhaus, M.D.
69 Butler Street, S.E., Atlanta 3
JACKSON 3-4711

CHEST

Joseph S. Cruise, M.D.
348 Peachtree Street, N.E., Atlanta 8
JACKSON 3-7726

DERMATOLOGY

William L. Dobes, M.D.
478 Peachtree Street, N.E., Atlanta 8
JACKSON 1-2428

DIABETES

Ralph A. Murphy, Jr., M.D.
478 Peachtree Street, N.E., Atlanta 8
JACKSON 3-2556

GENERAL PRACTICE

Clifton G. Kemper, M.D.
478 Peachtree Street, N.E., Atlanta 8
JACKSON 2-9671

MEDICINE

Joseph H. Hilsman, M.D.
1211 West Peachtree Street, N.E., Atlanta 9
TRINITY 5-6407

OBSTETRICS AND GYNECOLOGY

George A. Williams, M.D.
710 Peachtree Street, N.E., Atlanta 8
TRINITY 3-3311

OPHTHALMOLOGY AND OTOLARYNGOLOGY

James T. King, M.D.
340 Boulevard, N.E., Atlanta 12
JACKSON 3-8667

ORTHOPEDICS

J. Hiram Kite, M.D.
490 Peachtree Street, N.E., Atlanta 8
JACKSON 2-7303

PATHOLOGY

Hugh V. Bell, Jr., M.D.
300 Boulevard, N.E., Atlanta 12
JACKSON 5-7861 Ext. 331

PEDIATRICS

Joseph H. Patterson, M.D.
1405 Clifton Road, N.E., Atlanta 22
DRAKE 3-4401

PSYCHIATRY

John Warkentin, M.D.
2905 Peachtree Road, N.E., Atlanta 5
CEDAR 3-9401

RADIOLOGY

Ted F. Leigh, M.D.
Emory University Hospital, Atlanta 22
DRAKE 3-1621

SURGERY

A. Jack Crumbley, Jr., M.D.
683 Lee Street, S.W., Atlanta 10
PLAZA 5-6684

UROLOGY

Thomas J. Florence, M.D.
340 Boulevard, N.E., Atlanta 12
JACKSON 4-5082



heart page

STAPHYLOCOCCAL ENDOCARDITIS

Charles D. Hollis, Jr., M.D., *Albany*

THE STAPHYLOCOCCUS CONTINUES to cause dangerous and frequently fatal infections. Increasing numbers of reports are appearing of overwhelming staphylococcal infections totally resistant to, and many times occurring as a complication of, massive antibiotic treatment.

Whenever there is bacteremia during the course of a staphylococcal infection, endocarditis can develop. It is frequently unrecognized. In about 50 per cent of the cases this develops on a previously normal heart valve. The clinician can not depend on the pre-existence of a murmur as valid sign in directing him toward the diagnosis of staphylococcal endocarditis. This disease is unlike the endocarditis caused by the alpha or non-hemolytic streptococcus in that it occurs rather commonly on the valves of the right side of the heart.

Bacteremia and endocarditis are especially likely to occur when one encounters such situations as: (1) extensive, denuding skin diseases, particularly those under treatment with adrenal steroids and prophylactic tetracyclines; (2) chronic debilitating diseases such as leukemia or emphysema, again with the probability increased by prolonged therapy with adrenal steroids; (3) staphylococcal pneumonia; (4) osteomyelitis; (5) traumatized or manipulated infected tissue; (6) poorly drained, infected, sutured wounds; (7) ischemic ulcers, notably in diabetics, and (8) postoperative prostatic or urinary tract surgical cases.

Frequently, it is extremely difficult to recognize

this disease clinically. Initially, findings are only those of any severe systemic infection. Usually the course is that of an acute endocarditis with a dramatic change in the general condition of the patient. There is development of, or change in, a heart murmur, septic embolic phenomena, rapidly progressive heart failure, and shock. When involvement is on the right side of the heart, there are indications of multiple small pulmonary infarcts. Occasionally, obstructive lesions develop in the peripheral vessels. Because of the rapid progression of the disease, anemia, splenomegaly, and clubbing do not develop.

When the infecting organism is an albus or less virulent strain, the picture of a subacute endocarditis is sometimes seen. Abruptly this picture can change to that of a fulminating disease. At times the process is converted from an acute to a subacute one by treatment with antibiotics sufficient to suppress but not to eradicate the organism. This possibility should be considered whenever a staphylococcal infection is unusually slow in responding completely to treatment.

The question of endocarditis must be constantly entertained if the antimortem diagnosis is to be made.

Once compatible clinical findings are noted and the condition suspected, the obtaining of a positive blood culture confirms the diagnosis. Usually the organism is easily cultured, even when the lesion is on the right side of the heart.

Treatment of this condition must be instituted

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

promptly with large doses of the selected drugs and maintained for a period of six to eight weeks. Sensitivity studies of the cultured organism are very important and should be used as a guide in planning therapy. Trial therapy with inadequate amounts of the drugs allows overgrowth of resistant strains and is responsible for many treatment failures. Whereas in most infections the use of more than one antibiotic is unnecessary and frequently unwise. Here the combined use of the two most effective drugs in the maximum dose tolerated by the patient seems justified. Even if no additive or synergistic effect is obtained, one would hope by combined therapy to delay the emergence of resistant strains. The drugs most likely to be useful are vancomycin, penicillin, chloramphenicol, and erythromycin. Tetracyclines are less likely to provide significant activity against the staphylococcus. Recently results seem to indi-

cate that vancomycin is most often the drug of choice. If sensitivity tests indicate that the organism is responsive, this drug can be used in combination with penicillin, erythromycin, or chloramphenicol. Penicillin in doses of 50 to 100,000,000 units per day has been found to be effective even when the usual laboratory sensitivity tests indicate resistance of the organism. Administration of this dosage can be achieved by giving a constant infusion of the plain, aqueous penicillin G with periodic booster injections of 1,000,000 units into the tube.

The resulting mortality from staphylococcal endocarditis is still quite high. The diagnosis is still being made more often at the autopsy table than at the bedside. The cure rate can be significantly improved only when there has developed a keen awareness of the problem which will permit diagnosis early when the organism is still relatively sensitive and the destructive process of the disease is reversible.

CIRCULAR NURSING UNIT

A CIRCULAR NURSING unit, with the rooms surrounding a central nurses' station, makes patients happier and saves time and steps for nurses, a recent Rochester, Minn., study has shown.

The study, conducted at Methodist Hospital, Rochester, is reported in a new monograph, published recently by the American Hospital Association. The monograph is the eighth in a series dealing with various aspects of hospital operation.

The circular unit was constructed so the nurses' station was encircled by a corridor around which there were 12 private rooms for patients. Clear glass panels in the upper halves of the double doors of each room allowed nurses to observe patients from the nurses' station and the corridor. Each patient could see the nurses, but not patients in other rooms.

To test the effectiveness of the circular unit, it was compared to the usual rectangular unit, with the nurses' station midway in a corridor. The same staff—a head nurse, 13 staff nurses, three nurse aides, and one orderly—first staffed the rectangular unit and then the circular unit. The same 10 doctors had patients in both units, and the patients required similar postoperative care.

The patients said they felt secure because the nurses could see them at all times; they felt a sense of companionship, and they were diverted by watching the activity in the central area.

Physicians and nurses also preferred the circular unit

to the rectangular unit because they could observe patients continually and because it was compact.

The circular unit saved much time and distance in walking. In the rectangular unit the nurses spent more time in "precautionary observation at the bedside and in reassuring patients," the monograph authors said. In the circular unit, they spent more time in satisfying the specific needs of the patients which they did after observation from outside the rooms.

This saving in travel time ultimately resulted in reduced staffing, the authors said. After the study was completed and the circular unit was no longer a test ground, the number of staff nurses assigned to the unit was reduced by two.

The authors, in their conclusion, recommended that further studies be carried out to measure the effectiveness of circular units for types of care other than intensive postoperative care.

The authors of the monograph, entitled "Comparisons of Intensive Nursing Service in a Circular and Rectangular Unit," are Madelyne Sturdavant, research director at Methodist Hospital; David T. Carr, M.D., of the Mayo Clinic section of medicine; Robert P. Gage of the Mayo Clinic section of biometry and medical statistics; Raymond Keating, Jr., M.D., of the Mayo Clinic section of medicine; Harold C. Mickey, administrator of Methodist Hospital, and Edward H. Weld of the Mayo Clinic administrative unit, all of Rochester.



mental health page

AGGRESSION

Salmon A. Koff, M.D., *Atlanta*

WEBSTER DEFINES AGGRESSION as an act of hostility. Psychiatrists, however, in using this term, have given it more detailed meaning. They define aggression as a deep-seated drive or pattern of the personality to react in a definitely forceful way. The term carries a certain implication not only of will to power but of hostility and attack, although these tendencies need not be overtly expressed.

There are two theories regarding the origin of aggression. Some are of the opinion that aggression is an inherent, instinctive urge which develops spontaneously and may become manifest during the suckling period of development. Others believe that aggression arises as a response to the frustration of needs and impulses. Since frustration and deprivation are inevitable accompaniments of living, aggression arises as a natural sequence.

Under natural circumstances aggression may take one of two courses, depending upon the personality of the individual. On the one hand, it might be expressed by hostile attack; on the other hand, the individual may be so fearful of the potential of his hostility, that he turns the aggression inwardly (in which case it may become manifest as guilt or depression). Another way of putting this is by comparing the aggression of the former with a homicidal person who attacks others, and of the latter with a suicidal person who attacks himself.

However, the psyche has available to it some normal automatic adjustive mechanisms, namely: repression, reaction-formation, sublimation, and ra-

tionalization. Thus, when an aggressive idea, wish, or fantasy becomes intolerable, it may become unconscious and have no awareness of it (repression); or they may be transformed into contrasting positive, loving tendencies, expressed by oversolicitude and excessive tenderness (reaction-formation); or the energy connected with the aggression may be directed into a socially accepted channel, e.g., prize-fighter, or highly competitive business enterprise (sublimation); or one may justify or find reasons after thoughtful deliberation which fully explain the aggressive behavior (rationalization). Thus, these and other types of adjustive defenses tend not only to allay the anxiety connected with the fundamental and pervading aggression which the individual dares not face in its unadulterated form as hate and hostility, but aggression becomes a highly dynamic factor in determining personality trends and patterns of behavior.

When these afore-mentioned defenses are no longer adequate, more pathological "defenses" are utilized. These are the neurotic and psychotic defense mechanisms. Typical of a neurotic defense is the clinical example of the sergeant during World War II, who developed a paralysis of his right arm. Narcosynthesis brought out a desire to kill his lieutenant who was responsible for the death of many of his platoon buddies (hysteria). Another example of neurotic defense against aggression is that of the young mother who was unable to drive her car for fear of killing someone in an accident (phobia).

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

MENTAL HEALTH PAGE / Continued

Compulsive handwashing, to remove the blood from his intended victim, is an example of compulsive neurotic reaction.

In psychosis, most common defenses against aggression are withdrawal and regression, both of which are found in schizophrenics. In withdrawal, the individual isolates himself physically and spiritually from any sort of interpersonal relationship, living completely within his world of make believe, to avoid expression of his aggression. Regression may occur when the stress from the aggressive impulse is so severe that reversion to an earlier state of development, characterized by helplessness and even infantilism, may avert the aggressive impulse.

Aggression is also described by psychiatrists as a character and behavior disorder, occurring in physically adult individuals who are unable to maintain their emotional equilibrium and independence under minor or major stress, because of deficiencies in their emotional development. In some, their be-

havior disturbance is based on fixation of certain life-long character patterns; in others, their behavior is a regressive reaction due to severe stress.

Two specific types of behavioral disorder are recognized in which aggression may be either overt or covert. In the overt form, which is called "Aggressive Reaction," the dominant factor is a persistent reaction to frustration with irritability, temper tantrums, and destructive or aggressive behavior. In the covert form "Passive-Aggressive Reaction," the aggressiveness is expressed by passive measures, e.g., pouting, stubbornness, procrastination, inefficiency, and passive obstructionism.

Aggression, *per se*, generally results in individuals with these tendencies coming into conflict with the law, and being convicted for their offense, sentenced by the courts.

However, since most aggression is determined by personality trends and patterns of behavior, correction may be afforded by complete and adequate personality evaluations and long term psychotherapy.

MILLEDGEVILLE HOSPITAL GETS MEDICAL EDUCATOR

DR. JAMES B. CRAIG, 49, professor of psychiatry at Ohio State University College of Medicine and clinical director of the Columbus Psychiatric Institute and Hospital, Columbus, Ohio, began his duties recently as Director of Education Service at the Milledgeville State Hospital.

In announcing his arrival, Dr. Irville H. MacKinnon, superintendent of the Hospital, stated that Dr. Craig will be responsible for all the Hospital's training programs in association with Emory University and the Medical College of Georgia as well as staff training at the hospital. Dr. Craig will also be responsible for certain speaking engagements before civic and professional organizations.

"Dr. Craig's coming is a real milestone in Georgia's mental health program," Dr. MacKinnon said. "We can begin now to intensify all phases of our training including psychiatric residency, nurse training, psychiatric aides, social service, medical students, and various postgraduate programs. Dr. Craig is well qualified to handle all of these and I am more than delighted that we have been able to secure a man of his caliber for the State Hospital."

A native of Augusta, Dr. Craig was an honor graduate of the Medical College of Georgia in 1937. He interned at St. Joseph's Hospital in Ann Arbor, Michigan. His residency training in psychiatry was done at Mercywood Sanitarium and the Neuropsychiatric Institute, Ann Arbor, and the Sacred Heart Sanitarium

in Milwaukee, Wisconsin. He received his Master of Science degree at the University of Michigan in 1942. He was an instructor in psychiatry at the Neuropsychiatric Institute and at the University of Michigan before joining the U. S. Army in 1942. During four years with the Army Medical Corps, he rose from Captain to Lt. Colonel and was Chief of Neuropsychiatric Service, Camp Shelby Regional Hospital, Hattiesburg, Mississippi.

Following his discharge, Dr. Craig was in private practice in Savannah from 1946 to 1952 where he specialized in neurology and psychiatry. During this time he was consultant to the U. S. Marine Corps Hospital there and was instructor in psychiatry at St. Joseph's Hospital School of Nursing.

He joined the staff of Ohio State University in 1952 as associate professor, became a professor in 1955, and was certified in 1955 by the American Board of Psychiatry and Neurology. He is also certified as a mental hospital administrator. He was also attending psychiatrist at Ohio State Medical Center, psychiatric consultant to the Veterans Administration Hospital in Dayton, and neurologist and psychiatrist at the Columbus Veterans Mental Clinic.

Dr. Craig is a member of the American Psychiatric Association and the Central Psychiatric Association. While in Savannah, he was a member of the Medical Association of Georgia and the Southeastern Society of Neurology and Psychiatry. He is licensed to practice medicine in Michigan, Wisconsin, Georgia, and Ohio.



Legal page

VOLUNTARY STERILIZATION

John L. Moore, Jr., *Atlanta*

IN A MINNESOTA case decided in 1934, the plaintiff's wife had had difficulty in her first childbirth. The wife underwent a caesarean section in the delivery. The gynecologist advised that a second pregnancy would be dangerous to her life. The matter was discussed with the defendant surgeon who advised the husband to undergo a vasectomy. The defendant doctor explained to the husband and wife that the performance of a salpingectomy upon the wife was a more risky and serious procedure than the performance of the vasectomy on the husband. The husband and wife decided upon the vasectomy. The defendant doctor performed the vasectomy in his office and pronounced the operation a success. Plaintiff and his wife resumed normal relations and, in due course, the wife became pregnant again. She had a safe delivery by means of caesarean section. Shortly afterwards the husband brought suit for malpractice against defendant surgeon for failure to perform as he had promised. The trial court found for the doctor. On appeal the issue was whether the contract to perform surgery was enforceable at all. To be enforceable, the contract had to be consistent with public policy. The Supreme Court of Minnesota decided that the operation of vasectomy for the reasons stated, that is, for sound therapeutic reason concerning the wife's health, was not against public

policy. Having made that decision, the Court went on to hold that the plaintiff's suit was barred because he had consented to the procedure. The decision ends at that point although, because of procedural complications, the case presumably went back for trial on the issue of whether the surgeon had been negligent in the performance of the surgery.

Unfortunately, there has been no decision on this point in Georgia. In the November 1956 issue of *The Journal of The Medical Association of Georgia*, the writer of this Legal Page stated that he had had considerable inquiry from all over the State of Georgia by physicians for his opinion as to whether or not voluntary sterilization is legal in this State. The writer concluded that, because of the lack of any decision on the point in the State, he could not give an opinion except to state that if he were a physician he would not perform the operation. That advice remains good today.

An attempt was made in the 1957 General Assembly to pass a statute in Georgia clarifying the point. However, the bill died in a House committee after it had passed the Senate. Various groups have been studying the point in more recent years.

The point gained significance at the present time because of the severe criticism of eugenic sterilization carried in an article entitled "Reappraisal of

Prepared at the request of the Medical Association of Georgia. Mr. Moore is an associate in the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.

Eugenic Sterilization Laws" which appeared in the July 16, 1960, *Journal of The American Medical Association* beginning at page 1245. It is certain that groups responsible for administration of the eugenic sterilization laws of Georgia, which apply to inmates and patients of State institutions only, will study the whole approach to the problem. It is interesting to note that the eugenic sterilization statutes of South Carolina and Mississippi contain provisions stating that nothing in the eugenic sterilization statutes are to be taken to prevent surgical treatment for sound therapeutic reason of any person in

The case discussed in the text is *Christensen v. Thornby*, 192 Minn. 123, 255 N.W. 620, 93 A.L.R. 570 (Sup. Ct. Minn. 1934).

NEW COMMITMENT LAW GAINS ACCEPTANCE

SEVENTY-ONE COUNTIES representing 71 per cent of Georgia's population have shown acceptance of the new 1960 commitment law for the mentally ill.

Ordinaries from these counties have ordered three-month supplies of new commitment forms made available July 1 by the Division of Mental Health of the Georgia Department of Public Health.

The population of the 71 counties is over 2,800,000 by preliminary U. S. Census figures.

the State by a physician licensed by the State which treatment may *incidentally* involve the nullification or destruction of the reproductive functions. No such saving provision appears in the eugenic sterilization law of Georgia.

It is this writer's opinion that a complete reappraisal of the problem should be undertaken in Georgia. After such a reappraisal, it is submitted that the use of eugenic sterilization—involuntary sterilization based on the idea that mental defects are hereditary—should be severely limited. However, the law relating to voluntary sterilization should be clarified to make it clear that at least operations for sound therapeutic reasons of the health of the patient or the patient's spouse are entirely consistent with public policy of the State of Georgia.

"The new commitment law represents a modern, humane approach to mental illness by allowing the patient to exercise all his civil rights and in many other ways it has a beneficial effect on the patient and his family," said Dr. John Venable, director of the Health Department.

"We are pleased that the law has been so quickly accepted by officials on behalf of seven out of every ten of our citizens, and we hope that all counties will accept it as soon as possible," he said.

TREATMENT TRAINING RATE HIGH PRIORITY AT MENTAL HOSPITAL

TREATMENT OF NEW patients at Milledgeville State Hospital and training of psychiatrists and other personnel were given first priority in recent recommendations by the Governor's Advisory Committee on Mental Institutions.

The Committee has issued a 13-month report with recommendations after hearing recent criticisms of the Hospital and after making an inspection tour June 26.

The report covered the areas of food, sanitation, general repair, use of prisoners, employee morale, and treatment. It was signed by Dr. William Rottersman, Atlanta psychiatrist, who is chairman.

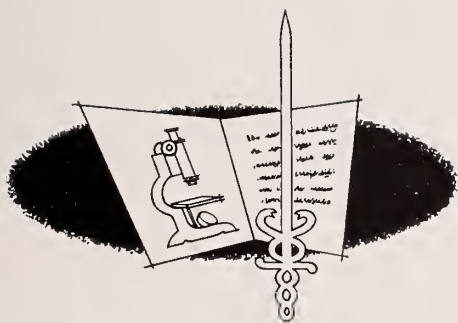
The Hospital's present practice of concentrating on intensive treatment of new patients was commended, as the report recognized the shortage of trained personnel and other resources. Over two-thirds of new patients are being discharged after less than two months, the report pointed out, whereas only a small percentage of patients who have been hospitalized more than two years are discharged.

To improve morale at the Hospital, the report recom-

mended more effective communication between the employees and the administration of the Hospital. In this connection, however, the Committee recognized the tremendous shortage of intermediate supervisors, and pointed out that the present "links in the chain of responsibility" are all persons who have "direct, back-breaking and overpoweringly immediate responsibilities for patients."

In other observations and recommendations, the report called for a reduction in the number of kitchens; expressed a general impression that wards and toilets are cleaner and brighter than on previous visits; noted that because of shortage of funds or because of earmarked funds, the Health Department has concentrated first on the safety of patients and second on the safety of valuable property; and felt that the use of prisoners permits the completion of projects today that would otherwise have to be put off for years.

The Committee also urged that the Hospital budget be greatly increased to carry out needed changes while mental health is at a high level of public interest, enthusiasm, and optimism.



cancer page

THE SERVICE PROGRAM OF THE AMERICAN CANCER SOCIETY, GEORGIA DIVISION

Robert L. Brown, M.D., *Atlanta*

ALTHOUGH RESEARCH and education are the major areas in which the American Cancer Society is engaged in the fight to conquer cancer, service to cancer patients is also part of the Cancer Society program. The Georgia Division of the American Cancer Society helps needy cancer patients in the following ways:

Transportation

When all other efforts fail to provide for transportation to and from State Aid Cancer Clinics, application for assistance in cases of dire need may be made to the American Cancer Society through the local unit. In most cases members of the family, neighbors, or cancer unit volunteers will provide free transportation if notified in advance. Some units have a well organized motor corp of volunteers. When ambulance service becomes necessary and cannot be otherwise provided, a letter from the director of the State Aid Clinic is required stating that this is necessary for the safety and welfare of the patient. The amount which can be expended for transportation for any one patient during a 12 months' period is limited to \$25 to \$35 depending

upon the distance from the treatment center. During the past year 831 patients in 131 counties received transportation to and from State Aid Clinics through the assistance of the American Cancer Society.

Pain Relieving Drugs

When the family is unable to pay for pain-relieving drugs for incurable cancer patients, the American Cancer Society will pay for morphine, codeine, and empirin compound with codeine. The limit is \$15 per month per patient up to a yearly total of \$50 per patient. Druggists cooperating with the Society in this program sell at cost or cost plus 10 per cent. Please ask for this cooperation. The procedure is for the service chairman of the local unit of the Cancer Society to authorize a charge account in the patient's name and the American Cancer Society. The person authorizing the account should notify the Cancer Society immediately and the drug bill should be signed by the service chairman. Bills listing the type of drug, strength, quantity in each prescription, the name of the licensed physician prescribing, the name of the patient and the amount

Approved by Professional Education Committee, Georgia Division, ACS

CANCER PAGE / Continued

charged should be sent monthly to the service chairman of the local unit. No bills more than 60 days old can be paid. It is very important that full information be listed on each bill. During the past year 1234 patients in 139 counties received pain-relieving drugs through the help of the American Cancer Society.

Sick Room Conveniences

Some American Cancer Society units maintain gift and loan closets containing hospital beds, wheelchairs, special mattresses, lifts, and many patient comforts. These will be loaned to patients when they are unable to buy such items. These closets also have some gift items such as pajamas, towels, etc. When no local unit loan closet is maintained, requests for such items should be sent to the Georgia Division headquarters and the items will be mailed from there if they are available. During the past year 120 patients in 12 counties received this type of assistance.

Dressings and Bandages

Hundreds of volunteers make dressings and bandages for patients throughout Georgia. The local unit of the American Cancer Society can order these materials direct from the Georgia Division headquarters if the need cannot be filled by the local unit. Last year 237 patients in 75 counties were supplied dressings and bandages which were made by American Cancer Society volunteers with materials purchased by your Cancer Society contributions.

Other Services

The Georgia Division of the American Cancer Society makes a contribution to the Visiting Nurses Association in Fulton, DeKalb, and Cobb counties which supports two visiting nurses. One visiting nurse is supported in Bibb County. Floyd County and Richmond County have a volunteer visiting nurse

service involving retired registered nurses which has been most helpful. The volunteer visiting nurses have been of great assistance to cancer patients who are confined to their homes and who require this type of nursing care and in transporting patients to and from clinics for treatment.

In some special cases where the Rehabilitation Division of the State Department of Education cannot aid a cancer patient in obtaining an artificial limb, eye, or brace, etc., the Cancer Society will arrange for the purchase of such appliance on the recommendation of the attending physician and the local Cancer Society unit. The Rehabilitation Division of the State Department of Education will give assistance when the patient is re-employable and this agency should always be contacted first.

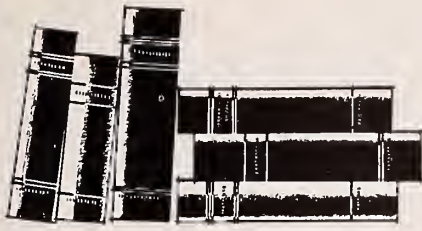
The Cancer Society also cooperates with the Georgia Laryngectomy Association and the Georgia Ileostomy and Colostomy Association. The members of these organizations are available to visit patients who have cancer of the larynx requiring laryngectomy or cancer of the intestine requiring colostomy or ileostomy, if the physician so desires. This is often very helpful for the patient because he has a chance to see how well some one else has overcome a similar handicap. For this service as well as for the others listed above, physicians may call or write to the Georgia Division of the American Cancer Society, 2025 Peachtree Road, N.E., Atlanta 9, Ga.

Our objective in this service program is to do everything possible in the above ways to help needy cancer patients in Georgia. We wish to spread the benefits as far as we can and therefore ask your cooperation. When service is needed, the Cancer Society endeavors to help regardless of the amount of funds contributed by the patient's county. Sixteen cents of every contributed dollar goes for services to needy cancer patients in Georgia under the current budget approved by the Board of the Georgia Division, American Cancer Society. One-half of the Board members are doctors.

CONTRIBUTORS TO AMEF

<i>Name</i>	<i>Address</i>
Chaney, Ralph	Augusta
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Habersham County Medical Society, Woman's Auxiliary	Cornelia
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<i>Name</i>	<i>Address</i>
Leigh, Ted F.	Atlanta
Nichols, Pomeroy	Augusta
O'Quinn, Silas E.	Glenwood
Rayle, Albert A., Jr.	Atlanta
Richmond County Medical Society, Woman's Auxiliary	Augusta
Wayne County Medical Society, Woman's Auxiliary	Jesup
Whitfield County Medical Society, Woman's Auxiliary	Dalton



physician's bookshelf

BOOKS RECEIVED

STEPS IN THE DEVELOPMENT OF INTEGRATED PSYCHIATRIC SERVICES, Report of the 3rd Meeting of the Advisory Council on Mental Health Demonstrations, Milbank Memorial Fund, New York, N. Y., 1960, 146 pp., \$1.00.

Grace, William J., M.D., **PRACTICAL CLINICAL MANAGEMENT OF ELECTROLYTE DISORDERS**, Appleton-Century-Crofts, Inc., New York, N. Y., 1960, 132 pp., \$4.95.

Cohn, Isidore, M.D. and Deutch, Hermann B., **RUDOLPH MATAS, A BIOGRAPHY OF ONE OF THE GREAT PIONEERS IN SURGERY**, Doubleday & Co., Inc., Garden City, N. Y., 1960, 431 pp., \$5.95.

Clark, Marguerite, **MEDICINE TODAY**, Funk & Wagnalls, New York, N. Y., 1960, 360 pp., \$4.95.

Schaffer, Alexander J., M.D., **DISEASES OF THE NEWBORN**, W. B. Saunders Co., Philadelphia, Pa., 1960, 878 pp., \$20.00.

REVIEWS

Roemer, Milton I., M.D., **SIGERIST ON THE SOCIOLOGY OF MEDICINE**, MD Publications, Inc., New York, N.Y., 1960, 397 pp., \$6.75.

WHILE THE READER of these previously unpublished brilliant essays might first gain the impression that Dr. Sigerist had a penchant for irritating the American physician, he soon gains respect, if not agreement, for the insight which this former Professor of the Johns Hopkins Institute of the History of Medicine had into the various systems of medical care the world over. This is not a book for the timid nor for him who fails to recognize some of the problems which face American medicine. These essays are a vertical penetration of the good and bad of medical care throughout the world with a somewhat jaundiced eye toward the West, a somewhat more sympathetic eye toward Russia and the East. But this is as one would expect from Dr. Sigerist, a renowned socialist who was for one reason or another hoodwinked by the information available to him in the 1930's regarding the health work in the Soviet Union.

If one will accept as information the hypercritical

Acknowledgement of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

essay on socialized medicine and the even more hyper-irritable essay, "Twenty-Five Years of Health Work in the Soviet Union," he will be thoroughly entertained and enlightened by others of the group such as that on the Eleventh International Congress of the History of Medicine and the touching but pathetic "The Need for an Institute of the History of Medicine in India," as well as his report on India.

The two final chapters on social medicine in medical education and what medicine has contributed are must reading for every premedical student and educator. "If medical education is to fulfill its purpose and is to train the physician not of yesterday but of tomorrow, we must have a clear picture of what kind of doctor our present industrial civilizations require. Today we are living in a time of transition, when social and economic conditions change rapidly, and medical science is progressing more than ever before in history. We need a physician who conscious of developments, conscious of the social functions of medicine, considers himself in the service of society—the social physician protecting the people and guiding them to a healthier and happier life."

Every American physician interested in knowing where we are going might well profit from these controversial pages. This is recommended reading for the officers of every county medical society and for the leadership of organized medicine.

Peter L. Scardino, M.D.

Wolstenholme, G. E. W., O.B.E., M.A., M.B., M.R.C.P.; O'Connor, Cecilia M., Sc., and O'Connor, Maeve, B.A., **CIBA FOUNDATION TENTH ANNIVERSARY SYMPOSIUM ON SIGNIFICANT TRENDS IN MEDICAL RESEARCH**, Little, Brown and Company, Boston, Mass., 1959, 356 pp., \$9.50.

THIS IS A Ciba Foundation Symposium volume, containing the transactions of a special symposium, arranged in celebration of the tenth anniversary of the Foundation. The symposium was held in London June 24-26, 1959. Those participating were such outstanding scientists as C. H. Best, Sir Russel Brain, Sir Hans Krebs, Linus Pauling, Sir George Pickering, J. Waldenstrom, and 24 others, representing the fields of physiology, medicine, pathology, biochemistry, zoology, public health, and genetics.

All of the lectures and discussions are most erudite and extremely interesting, though they are often too technical for a clinician to understand. The most inter-

PHYSICIAN'S BOOKSHELF / Continued

esting is L. Pauling's paper on molecular structure in relation to biology and medicine. The discussion is brief but thought-provoking. Pauling's ideas are based mainly on his researches with the molecular structure of hemoglobins. He predicts that we shall know within 25 years how genes duplicate themselves, how enzymes work, how protein molecules are synthesized, how abnormal molecules cause diseases, and how drugs and hormones achieve their effects.

Dr. H. Thorell of the Nobel Institute discusses studies of enzyme complexes. This paper is very technical and deals with chemistry, biochemistry, physiochemistry, and advanced mathematics. It is apt to be incomprehensible to the average doctor but will give him some insight into how research is being done in this important field.

There is an interesting paper on the chemical basis of virus multiplication. It points out that the function of a gene is the production of an enzyme. The sum of enzymes, their distribution and appearance during development, determines the morphology and metabolism of the organism. This paper reports on researches into the chemical and physical structure and genetic material of viruses. This research is throwing light on general biological processes.

Sir Macfarlane Burnet discusses population dynamics of body cells. He believes that somatic mutation is a process of extreme importance in medicine, that the phenomena of immunity are based on evolved specialization of the capacity of all cells to mutate, that cancer is a manifestation of the selective short-term survival of cells which have gained proliferative advantage by sequential mutation, and that old age and death represent the cumulative effect of a burden of somatic mutation in the body cells.

Jan Waldenstrom writes about genetics and medicine. He points out that inborn errors of metabolism are consequences of abnormal templates for protein synthesis. One abnormal gene, producing one abnormal enzyme, is seen as the cause of hereditary disease.

Alexander von Muralt writes about the last ten years of research in general neurophysiology. He discusses the ionic or membrane theory of excitation, quantal phenomena, saltatory conduction, heat and metabolic measurements, and the motor end-plate.

F. G. Young discusses the nature and mechanism of action of hormones. He points out that much has been

learned about the structure of peptide hormones but much less about their mechanism of action.

Dr. Best's paper is concerned with metabolic problems involving the pancreas, choline, insulin, and glucagon. Dr. D. W. Richards discusses research in chronic pulmonary disease, mechanics of breathing, pulmonary diffusion, pulmonary circulation, ventilation, perfusion, and studies with radioactive krypton. A. Haddow reports on the mechanisms and nature of malignant transformation. This paper contains nothing new or startling.

Dr. J. F. Brock of the University of Cape Town writes about research in clinical nutrition. Sir George Pickering writes about the quantitative approach to disease as exemplified by essential hypertension. J. A. Shannon discusses the factors influencing the substance and dimension of medical research in the United States.

On the whole, the book is stimulating and thought-provoking. It makes one hopeful for major advances in medical knowledge, while being made at the same time painfully aware of the narrow dimensions of our knowledge and the great complexities involved in pushing back the frontier.

Arthur M. Knight, M.D.

Gardner, Ernest, M.D.; Gray, Donald J., Ph.D., and O'Rahilly, Ronan, M.Sc., M.D., *ANATOMY*, W. B. Saunders Co., Philadelphia, Pa., 1960, 999 pp.

THIS NEW BOOK on anatomy is one of the most readable and easy to follow texts I have seen. It stresses quite well the intimate relationship and importance between structure and function. Although it has particular and comprehensive treatment of neuroanatomy, histology, embryology, and comparative anatomy, it does deal with the essentials here and its list of relevant references for the advanced and postgraduate student is excellent. An emphasis is made on the fact that the study of anatomy is a living thing and that new facets and different approaches to this science are constantly being found.

The sections on lungs and skeleton with the excellent illustrative x-ray film are splendid.

Although Henselmann, the artist, did not use multi-colored drawings in his legends, for the most part they are well done and certainly appropriately located in most all portions of the text.

The book is well written; the illustrations most appropriate, and as the authors state their approach, one of moderate regionalism, is well executed.

Robert H. Vaughan, M.D.

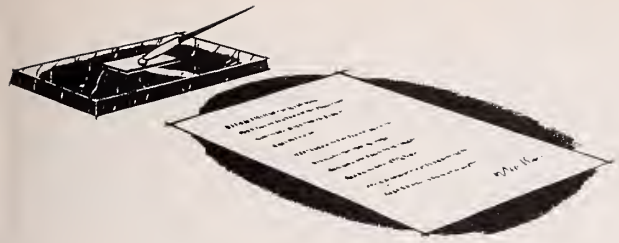
AMERICAN UROLOGICAL ASSOCIATION OFFERS AWARD

THE AMERICAN UROLOGICAL ASSOCIATION offers an annual award of \$1,000 (first prize of \$500, second prize \$300, and third prize \$200) for essays on the result of some clinical or laboratory research in Urology. Competition is limited to urologists who have been graduated not more than ten years, and to hospital internes and residents doing research work in Urology. "The first prize essay will appear on the program of

the forthcoming meeting of the American Urological Association, to be held at the Hotel Biltmore, Los Angeles, California, May 22-25, 1961.

"For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland, Essays must be in his hands before December 1, 1960."

abstracts by georgia authors



Skandalakis, John E.; Gray, Stephen W., Ph.D., and Shepard, Duncan, 1968 Peachtree Road, N.E., Atlanta 9, Georgia, "Leiomyoma and Leiomyosarcoma of the Stomach," South. M.J., (May) 1960.

Smooth muscle tumors of the stomach, once considered quite rare, are being recognized with increasing frequency. About 1,000 cases are now recorded, of which more than 600 have been reported since 1938.

Over the past 18 years, 17 leiomyomas and nine leiomyosarcomas have been seen in Atlanta hospitals and are reported in this paper.

Symptoms are hemorrhage, pain, and palpable mass, but many tumors are silent. One patient with a leiomyosarcoma 17 x 14 x 9 cms. had no symptoms. Two other patients with leiomyomas were also asymptomatic. There are no certain criteria on which to base a diagnosis. That eight out of 22 preoperative diagnoses were correct can be considered better than would be expected. One leiomyoma patient and four leiomyosarcoma patients died postoperatively. Three patients with leiomyosarcoma died unoperated.

One case of a benign tumor with possible sarcomatous changes is discussed. As only about one quarter of leiomyosarcomas metastasize, the distinction between benign and malignant tumors is difficult to make. The problem of malignant degeneration of benign smooth muscle tumors is discussed.

Prince, Charles L. and Scardino, Peter L., 2515 Habersham Street, Savannah, Georgia, "A Statistical Analysis of Uteral Calculi," J. Urol. 83:561-566, (May) 1960.

A statistical and critical evaluation of 922 cases of ureteral calculi is presented. Of special interest and possible importance in the study of urolithiasis are the observations which relate to: (1) the higher incidence of stone formation in the white population of Southeastern United States; (2) new evidence which concerns the reversal of the sex-stone relationship in younger persons, in older age groups stones occurring twice as often in the male population as in the female, while in the younger group the opposite is true; (3) the significance of a definite seasonal occurrence of ureteral calculi with the large majority occurring during the hot summer months, and (4) pregnancy apparently fails to protect the expectant mother from forming

urinary tract calculi, as has often been stated. The incidence of urolithiasis during pregnancy is abnormally high.

Approximately 40 per cent of the patients with ureteral calculi will pass their stones spontaneously. Cystoscopic removal of stones in the lower ureter is safe and effective. In our hands the procedure has been successful in 65.4 per cent of the cases in which it has been used.

Of the 922 cases of ureterolithiasis studied, 15.3 per cent gave a history of previous calculous disease, and in this series there was a known recurrence rate of 8.8 per cent. What is it that these multiple stone forming patients have in common? What is it that they fail to share with that large majority of stone bearing patients who never have more than one calculus?

Birch, Herbert W., 69 Butler Street, S.E., Atlanta 3, Georgia, and Collins, Jason H., New Orleans, Louisiana, "The Vulvar Clinic: A Teaching and Research Project," South. M.J. 53:473-477, (April) 1960.

The establishment of a Vulvar Clinic has been shown to lend itself quite well to significant progress in the understanding and treatment of lesions of the vulva. Two hundred and twenty new patients have been registered into this Clinic over the first two year period. By having a team of gynecologists and dermatologists, this Clinic has demonstrated its advantages for graduate and postgraduate teaching. The Clinic has also provided the excellent follow-up so necessary to carry out any valid investigative work. A thorough vulvar survey is used, including venereal disease studies, smears, cultures, and biopsies. The glucose tolerance test was frequently performed for patients with persistent vulvitis with a very high yield of diabetics and prediabetics. The early diagnosis and treatment of vulvar malignancies was stressed. Obviously, the patients profit by this thorough approach and are afforded the best possible treatment.

Brown, William J., M.D.; Price, Eleanor V., and Simpson, W. G., M.D., Venereal Disease Branch C.D.C., Atlanta, Georgia, "The Reiter Protein Antigen Test Compared with the T.P.I. and other Treponemal and Nontreponemal Antigen Technics in the Diagnosis of Syphilis," J. Invest. Dermat. 34: 223-227, (March) 1960.

This presentation is based on the Kolmer Reiter Protein (KRP) test

performed at the Venereal Disease Research Laboratory. This was the only one of the Reiter protein tests to maintain the same level of sensitivity in both the untreated syphilis study conducted in Macon, Georgia, and the study known as the Serologic Evaluation Research Assembly (SERA). The KRP test had a sensitivity rating of 80.8 per cent or 2.6 per cent above average and a specificity rating of 95.3 per cent or 0.7 per cent below average.

The results of the KRP on specimens from patients in various syphilitic categories (untreated early, treated early, adequately treated late, untreated, and inadequately treated) ranged from 22 per cent in inadequately treated syphilis to 91 per cent in adequately treated syphilis, reactivity depending on stage of syphilis and duration of infection as well as treatment.

In comparison with three *Treponema pallidum* antigen tests and one non-treponemal antigen test in these same categories the reactivity of the VDRL slide and the TPCF tests had only a very slight edge over the KRP in the untreated early syphilis group. The TPI test had the lowest reactivity rate in untreated and in treated early syphilis, undoubtedly the result of the slow development of the TPI antibody and of cases being placed under treatment before the development of the antibody, for, in the categories which emphasize the effect of time, the three tests retaining the highest percentage of reactivity all employ *Treponema pallidum* antigen. With few exceptions, the similarity of test results is impressive.

On the basis of the similarity of results in SERA between the Reiter protein tests and the TPI tests in the syphilitic categories and almost equal specificity (96.0 per cent compared with 96.2 per cent) in the nonsyphilitic categories and the fact that they are inexpensive tests to perform, the Reiter protein tests are being substituted in some areas for the TPI test in differentiating syphilis from biologic false positive reactors.

Atwater, John S., M.D. and Carson, James M., M.D., 478 Peachtree Street, N.E., Atlanta 8, Georgia, "Therapeutic Principles in Management of Peptic Ulcer," Am. J. Digestive Diseases 4:1055-1065, (Dec.) 1959.

This is a comparative study of treatment of peptic ulcer in 303 patients over 36 months period using placebo, atropine, anticholinergic and anticho-

ABSTRACTS / Continued

linergic-tranquilizer drugs, and at the same time adhering to the same basic medical management, viz; and ambulatory ulcer type diet (four to six feedings daily) and on absorbent antacid preparation with one half glass of milk every two hours while awake, and avoidance of contributory factors, such as caffeine-bearing beverages, alcohol, and tobacco.

The results obtained revealed that the patients treated with anticholinergic drugs induced "good to excellent" results in a statistically greater number of patients than did either placebo or atropine. Furthermore, the addition of a tranquilizer (meprobamate) induced

"good to excellent" results more often than did an anticholinergic drug alone.

Another salient feature of this study is that no patient on the anticholinergic tranquilizer combination developed any of the complications of hemorrhage, perforation or the necessity of operative intervention during the three year period.

This suggests that the addition of such a combination enhances the over all expectancy and prognosis of a peptic ulcer patient.

McLaren, J. R.; Galambos, J. R.; Pearson, H. O., Jr., and Weens, H. S., 69 Butler Street, S.E., Atlanta 5, Georgia, "The Hepatic Uptake of Radioactive Iodipamide for the Evaluating of Liver Function," *South M. J.* 53:622-625, (May) 1960.

Following the intravenous injection of radioactive iodopamide, there is a significant difference in the uptake of radioactivity by the liver of patients with and without proven liver dysfunction. There was an average decrease of 3.3 per cent radioactivity below equilibrium levels over the livers of patients with liver disease, whereas those patients with normal liver function showed an average increase of 25.3 per cent of radioactivity over their livers.

Correlation between this test and more commonly used tests of liver function is demonstrated.

Preliminary work suggests that the test may also be used to predict whether or not patients will opacify their biliary tree on subsequent intravenous cholangiography.

1960-61 CALENDAR OF MEETINGS

State

- Sept. 29-Oct. 1—Georgia TB Association and Georgia Trudeau Society, DeSoto Hotel, Savannah.
- Oct. 12-13—Annual Meeting, Georgia Academy of General Practice, Dinkler Plaza, Atlanta.
- Nov. 29-Dec. 1—"Fractures in General Practice," Medical College of Georgia, Augusta.
- Dec. 1-2—Postgraduate Course in Ophthalmic Surgery, Emory University School of Medicine, Grady Memorial Hospital, Atlanta.
- Dec. 6-8—"Workshop on Diabetes," Medical College of Georgia, Augusta.
- Jan. 24-26—"Problems of the Newborn Infant," Medical College of Georgia, Augusta.
- Feb. 19-22—Atlanta Graduate Assembly, Biltmore Hotel, Atlanta.
- Feb. 28-Mar. 2—"Management of Your Patient with Vascular Disease," Medical College of Georgia, Augusta.
- May 7-10—Annual Session, Medical Association of Georgia, Atlanta Biltmore Hotel, Atlanta.**

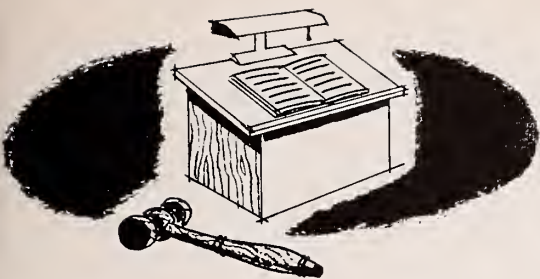
Regional

- Sept. 26-27—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tennessee.
- Oct. 12-23—Postgraduate Medical Seminar Cruise in Caribbean sponsored by the University of Florida College of Medicine, Gainesville, Florida.
- Oct. 21-22—Southeastern Allergy Association, Atlanta Biltmore Hotel, Atlanta, Georgia.
- Oct. 30-31—Southern Chapter, American College of Chest Physicians, Statler Hilton Hotel, St. Louis, Missouri.
- Oct. 31-Nov. 3—Southern Medical Association, St. Louis, Missouri.
- Oct. 31-Nov. 3—Interstate Postgraduate Medical Association, 45th Scientific Assembly, Pittsburgh Hilton Hotel, Pittsburgh, Pennsylvania.
- Nov. 9-18—Postgraduate Medical Seminar Cruise to the West Indies sponsored by Duke University Medical School, Durham, North Carolina.
- Dec. 6-8—Southern Surgical Association, Boca Raton Hotel, Boca Raton, Florida.

- Jan. 16-18—Sectional Meeting, American College of Surgeons, Hotel Dinkler-Tutwiler, Birmingham, Alabama.

National

- Sept. 24-27—College of American Pathologists, Palmer House, Chicago, Illinois.
- Sept. 24-Oct. 2—American Society of Clinical Pathologists, Palmer House, Chicago, Illinois.
- Oct. 2-7—American Society of Anesthesiologists, Inc., Statler-Hilton Hotel, New York, New York.
- Oct. 5-8—American Academy for Cerebral Palsy, Penn-Sheraton Hotel, Pittsburgh, Pennsylvania.
- Oct. 8—Sixth Annual meeting, American Rhinologic Society, Belmont Hotel, Chicago, Illinois.
- Oct. 9-14—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Illinois.
- Oct. 10-12—Congress on Industrial Health, Hotel Charlotte, Charlotte, North Carolina.
- Oct. 10-14—American College of Surgeons, Clinical Congress, San Francisco, California.
- Oct. 17-20—American Academy of Pediatrics, Palmer House, Chicago, Illinois.
- Oct. 18—American Association of Poison Control Centers, Palmer House, Chicago, Illinois.
- Oct. 21-25—American Heart Association, Inc., Jefferson Hotel, St. Louis, Missouri.
- Oct. 31-Nov. 4—American Public Health Association, San Francisco, California.
- Nov. 3-5—Postgraduate Course in Fractures, The Stanley Hotel, Estes Park, Colorado.
- Nov. 28-Dec. 2—American Medical Association, Clinical Meeting, Washington, D. C.**
- Dec. 4-9—Radiological Society of North America, Netherland Hilton Hotel, Cincinnati, Ohio.
- Jan. 9-14—Postgraduate Course in General Practice Review, University of Colorado Medical Center, Denver, Colorado.
- Mar. 20-24—Postgraduate Course in Medical Technology, University of Colorado Medical Center, Denver, Colorado.



president's letter

ACCREDITATION OF SMALLER HOSPITALS

THE PURPOSE AND FUNCTION of the medical profession is to promote the best of health for everyone. It is the responsibility of the Medical Association of Georgia to encourage any program that will improve the health of the people of Georgia. For years there has been a National Accreditation Program for the larger hospitals, but it has been impossible for them to inspect hospitals with less than 50 beds.

In keeping with this, a program sponsored by the Georgia Hospital-Medical Council and approved by its respective component members is an accreditation or rather a program to give recognition by appropriate certificates to the smaller hospitals who meet certain standards. This program has been developed by doctors, hospital administrators, and hospital governing board members to apply to the problems in Georgia. This program's purpose is to aid the smaller hospitals, particularly those of 25 beds and under, in setting up standards by which it is felt patient care will be improved. It is strictly voluntary—it is not a "police action" program. The standards have been set up in booklet form, simple and flexible.

When a hospital requests accreditation, a "team" of your fellow physicians and hospital administrators who know hospital problems will meet with representatives of your governing board, medical staff, and administrator to discuss the requirements and how your hospital can be recognized as one of the better smaller hospitals in Georgia. Later this same team will return to check and see if the standard requirements have been met and a check list filled out.

Their report along with your hospital report will be reviewed by the Georgia Hospital-Medical Council and approval granted or recommendations made. Approval shall be only for a one-year period of time



MILFORD B. HATCHER, M.D.

with renewal of approval as long as the requirements are met.

It is felt that this will give the physician a better place to work. The governing board and administrator will have standards to go by with consultation of others with similar problems, and there will be better liaison of all hospital departments.

The Georgia Hospital-Medical Council was first organized as a mediation board, and it will still serve this function if the need should arise. Any hospital needing this service should get the governing board, hospital administrator, and the medical staff to all agree and request the consultation and recommendations of this board.

This is the first and only council of its kind, to my knowledge, in the United States and is being observed with interest by a number of other states.

For any information concerning the Georgia Hospital-Medical Council or its functions, contact your Medical Association Headquarters.

President, Medical Association of Georgia



current clinical concepts

Closed-Chest Cardiac Massage

THE PRINCIPLE OF the method is based on anatomical consideration. The heart is limited anteriorly by the sternum and posteriorly by the vertebral bodies; lateral motion is restricted by the pericardium. Pressure on the sternum compresses the heart between it and the spine, forcing out blood. Relaxation allows the heart to fill.

The patient should be supine on a rigid surface. The heel of one hand with the other on top of it, is placed on the sternum just cephalad to the xiphoid. Firm pressure (enough to move the sternum 3-4cm inward) is applied 60 times per minute. In 20 patients an overall survival rate of 70 per cent is described. In ventricular fibrillation, a closed-chest A.C. defibrillator is used.

Kouwenhoven, W. B., M.D. Ing, J. R., M.D., and Knickerbocker, G.G., M.S.E., JAMA 173:1064-1067, July 9, 1960.

Emotional Hypertension

AN INGENIOUS EXPERIMENTAL situation was set up by certain Russian workers at the primate station in Zukhumi. Baboons who had become self-selected mates were separated. The female was placed in the large cage with a strange male. Her mate was placed alone in a smaller cage alongside. The workers observed that the cuckolded mate regularly developed sustained hypertension.

Wolf, S.: Stress and Heart Disease, Mod. Concepts of Cardiovasc. Dis. 29:599, 1960.

Relief of Arthritic Pain and Rehabilitation of Chronic Arthritic Patient by Extended Sympathetic Denervation

EMPLOYED A TECHNIC of extended lumbar sympathectomy (excision of lumbar sympathetic ganglia and intervening trunk from the crus intermedius of the diaphragm distally to the superior margins of the common iliac vessels). Authors performed operation in 15 patients with advanced arthritis and intractable pain in weight bearing joints in the three and a half years prior to this report. In both rheumatoid arthritis and osteoarthritis, the procedure has

consistently provided relief from joint pain. Functional capacity has also been improved. More recently 14 additional patients have been similarly benefited.

Herfort, Robert, M.D. and Nickerson, S. Harold, M.D., Arch. of Physical Medicine & Rehabilitation, 40:133-140, April, 1959.

Erythematous, Pruritic Rash

A CONTRIBUTING EDITOR took one capsule of Mer/29 and developed a generalized erythematous, pruritic rash.

Personal communication.

Myocardial Changes in Lead Poisoning

THE CONCEPT OF "angina pectoris saturnina" was introduced in 1926 to describe the syndrome of palpitations, dyspnea, and precordial discomfort in young adults with chronic lead poisoning. Spasm of the coronary vessels caused by the lead was thought to be responsible for the symptoms, and definite ECG changes were present.

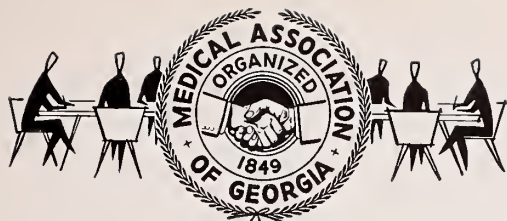
It is important to recognize this myocardial involvement in cases of lead poisoning and to ECG's in proven and suspected cases, so as to apply timely supportive measures.

Kline, T. S.: Myocardial Changes in Lead Poisoning, J. A.M.A., Dis. Child. 99:48-54, 1960.

Urine Electrophoresis in Patients with Multiple Myeloma

THIS STUDY REAFFIRMS the finding that Bence Jones proteins are encountered in about one-half of all patients with multiple myeloma. Patients whose sera do not contain a characteristic paraprotein peak almost always show a sharply defined microglobulin peak in the urine. The authors state that simultaneous electrophoresis of serum and urine concentrates probably constitute the most accurate diagnostic test for multiple myeloma.

Zinneman, H. H.; Glenchur, H., and Gleason, D. F.: The Significance of Urine Electrophoresis in Patients with Multiple Myeloma, Arch. Int. Med. 106:62-68, 1960.



the association

DEATHS

JOHN L. TAYLOR, 79, Franklin, died July 18 after an extended illness.

A native of Roanoke, Ala., Dr. Taylor attended public schools in Roanoke and graduated from Roanoke Normal College, the Atlanta School of Medicine, and Emory University School of Medicine.

Dr. Taylor had made his home in Heard County for more than 50 years, having begun the practice of medicine there in 1909. He received his 50-year pin from the Medical Association of Georgia in 1959.

He was a member of the Troup County Medical Society and was the oldest member of the LaGrange chapter of the Emory University Alumni Association.

Survivors include three daughters, Mrs. Grady Ridley and Mrs. Turner Quillian, both of LaGrange, and Mrs. Jim T. Mickle, Franklin; a son, James W. Taylor, LaGrange; six grandchildren, and four great-grandchildren.

PERSONALS

First District

ROBERT H. MORELAND, JR., a native Georgian, has opened offices for the general practice of medicine in Port Wentworth.

Second District

No news submitted.

Third District

JULIAN J. SIZEMORE, GEORGE S. WHATLEY, and FRANK L. BECKEL, all of Columbus, have been named to the new medical advisory committee for the Chattahoochee-Muscogee Chapter, the National Foundation.

Fourth District

ERNEST E. PROCTOR, JR., Newnan, was recently chosen as "Man of the Week" by the *Millen News*.

Fifth District

SANFORD J. MATTHEWS, Atlanta, was recently elected a member of the Medical Advisory Committee of the Crippled Children's Division of the Georgia State

Department of Health. He continues as Medical Director of the Seizure Program for the Crippled Children's Division.

BERNARD S. LIPMAN, Atlanta, has been appointed co-director of the Giddings Memorial Heart Clinic and will serve on the executive committee of the Clinic. He also has been appointed governor for Georgia for the American College of Cardiology.

Sixth District

C. R. IVEY, Macon, has opened his office on Marshall Ave. for the practice of pediatrics and general medicine.

JAMES BAUGH, Milledgeville, has been named chief of staff for the medical staff at the Baldwin County Hospital. HOWARD CARY and ZEB BURRELL, both of Milledgeville, were named vice-chief and secretary, respectively.

JAMES W. BURNHAM, Macon, has located on Jeffersonville Road for the practice of general medicine.

Seventh District

CLYDE V. TANNER and DONALD R. THOMAS are now associated with LLOYD YEARGIN in Dalton.

PAUL E. FITZPATRICK has located in Dalton for the practice of internal medicine.

MURRAY LUMPKIN is associated with PAUL BRADLEY for the practice of general surgery in Dalton.

The new chairman of the Chattooga County Tuberculosis Association is VIVION F. SHULL, Summerville.

WILLIAM R. THOMPSON has returned to Calhoun to resume the practice of medicine and surgery in association with CHARLES K. RICHARDS and BILL PURCELL.

The following officers have been named for the Floyd County Hospital Authority: HARLAN STARR, president; R. J. BLACK, president-elect; SAM GARNER, vice president, and TOM MOSS, JR., Secretary.

Eighth District

A. P. OHLMACHER, Baxley has been appointed to the consulting staff of the Bacon County Hospital.

Ninth District

ROBERT E. SHIFLET, Toccoa, left recently for Orlando, Fla., to complete his residency in urology at Orange Memorial Hospital.

STERLING A. HARRIS, Buford, has returned to

his office in the Doctors Building to resume full time practice after being away for the past year doing post-graduate study.

W. BRUCE SCHAEFER, Toccoa, recently assisted a young doctor in Los Angeles who once understudied him during World War II.

Tenth District

J. H. NICHOLSON, Madison, was recently guest speaker during ceremonies at the Presbyterian Church when 15 volunteer nurse's aids were capped.

WILLIAM F. HAMILTON, Augusta, has retired as chairman of the Department of Physiology at the Medical College of Georgia, but will continue as professor emeritus and carry on his cardiovascular research projects.

V. P. SYDENSTRICKER, Augusta, professor emeritus of the Medical College of Georgia, delivered the dedicatory address for University Hospital's new Hervey M. Cleckley psychiatric building.

SOCIETIES

The August meeting of the BIBB COUNTY MEDICAL SOCIETY was their annual picnic held at the lake of Sam Patton.

Cargo for a Friend-ship to Korea, estimated to be worth \$1,200,000, includes drugs contributed by the COWETA COUNTY MEDICAL SOCIETY.

The regular meeting of the WARE COUNTY MEDICAL SOCIETY was held recently at the Okefenokee Golf Club, with S. William Clark, Jr. presenting the program on "Glaucoma."

RESOLUTION ON THE DEATH OF

DR. J. B. KAY

THE AVERAGE DOCTOR, like the average man, appears on the stage of life and does the accustomed things; lives the ordinary life, and then passes from the scene.

He gives what he has to offer; he serves to the best of his ability, but there is nothing unusual about him, and posterity remembers him as just an average person.

But every now and then there appears on the scene, a man who is so different. He stands out from the others and towers above them. To him, life is a real challenge and he meets it calmly and without fear. He can walk with kings but never loses the common touch. He instinctively loves people and people instinctively love him.

If he is a doctor, he carries with him that calmness

and assurance that makes people feel better as soon as he sees them, and gives them the courage to overcome pain and suffering and get well.

That man usually turns to a small community for his home, because he wants to live with and be close to his patients. Though he chooses such a place, the world will seek and find him and make a beaten track to his door.

Such a man and such a life was the story of our beloved and fallen comrade, Dr. J. B. Kay, of Byron, Georgia. His main business in life was just being a country doctor, but he was much sought out for his skill and diagnosis and much beloved for his loving heart.

His was a humanity that showed in his daily life, tenderness and consideration to the weak, infinite pity to the suffering, and broad charity to all.

He held nothing back; he gave all; he added to the sum of human happiness, and if everyone for whom he did some loving service were counted, a multitude would stand before us.

To us his epitaph shall always be "there was, there is no stronger, gentler, manlier man, and medicine is proud to have had him in its ranks."

And so be it resolved that it is the sense of this medical society that we shall miss him, remember him, and give thanks that we had him as long as we did, and that each of us will hold his head a little higher because he lived among us.

Be it further resolved that a copy of this be spread upon our minutes in perpetuity, and another copy sent to his family.

Dr. Charles Richardson, Sr.

Dr. Thomas L. Ross, Jr.

Dr. Thomas Harrold

COUNTY MEDICAL SOCIETY EXECUTIVE

SECRETARIES MEET

EXECUTIVE SECRETARIES REPRESENTING five county medical societies in Georgia attended a one-day session at the new MAG headquarters office in Atlanta on August 9, 1960. The purpose of this meeting was to form a closer liaison between the lay staff of the MAG headquarters office and the lay staff of the larger county medical societies in Georgia.

Whitfield County Medical Society was represented by Mrs. John Lord; Muscogee County Medical Society by Mrs. Barbara Walden; Richmond County Medical Society by Mr. L. M. Morris; Floyd County Medical Society by Mrs. Charles Dent, and Fulton County Medical Society by Mrs. Ann Barrett.

After a tour of the MAG Headquarters Office, the function and facilities of MAG were explained and discussed in detail. Dr. John Mauldin, MAG Secretary, presented organization and policy procedures of the American Medical Association and Dr. J. G. McDaniel, MAG Council Chairman, discussed MAG policy procedures. The rest of the program was devoted to an open discussion of closer relationships between MAG and its component county medical societies. The meeting closed with representations of county medical society programs and projects.

STANDARDIZATION OF BLOOD BANKS IN GEORGIA

FOUR ORGANIZATIONS RECENTLY appointed representatives to form the Georgia Interagency Committee on Blood Services. Member organizations included the Medical Association of Georgia, the Georgia Hospital Association, the State Department of Public Health, and Georgia State Civil Defense Health Service.

The purpose of this committee is to study and devise "ways and means" of establishing standard blood banking services throughout all hospitals in Georgia. Dr. Lester Forbes, Atlanta, was elected chairman of the committee with Dr. James C. Thoroughman, Atlanta, serving as vice chairman. Mr. Robert Zwald, Atlanta, was elected secretary-treasurer.

The committee recommended that a study of the present blood service facilities in the hospitals of Georgia be undertaken. This survey will be used for the basis of recommendations in the improvement of standard blood services systems. The Interagency Committee will meet again within the next two months to analyze the results of this survey.

Executive Committee of Council Meeting Minutes

THE JULY MEETING of the Medical Association of Georgia Executive Committee of Council was called to order by Chairman Milford B. Hatcher at 3:30 P.M. at Fred Simonton's Farm, Centralhatchee, Georgia on July 23, 1960.

Mr. Krueger reviewed the Council Meeting Minutes of June 25-26, 1960 and the following corrections were noted: (1) that on page three of the Council minutes in the item concerning the Chairmanship of the AMA Delegation it was recommended that it read, "on motion duly made and seconded, it was approved that the Senior AMA Delegate would be Chairman of the MAG-AMA Delegation"; (2) that on page nine of the Council minutes in the second paragraph concerning the discussion with the Council of the possibilities of MAG considering the payment of the MAG-AMA Delegates expenses, etc., it was recommended that the sentence read, "Drs. Tift and Allen discussed with the Council the possibility of MAG considering the payment of the MAG-AMA Alternate Delegates expenses, etc.,"; and (3) further on page nine of Council minutes concerning the selection of key men on the county society level it was recommended that the motion be corrected as follows, "on motion made by Dr. Hatcher and duly seconded, this matter was referred to the Legislative Committee for action with the recommendation that the Legislative Committee request each county medical society to make these nominations, thus leaving the final appointment to the discretion of the Legislative Committee."

Mr. Krueger read the Executive Committee of Council meeting minutes of June 26, 1960 which were duly approved as read.

MAG-AMA Delegation Chairmanship

After discussion of the previous Council meeting action in making the Senior MAG-AMA Delegate Chairman of the delegation, it was moved and duly seconded that the Executive Committee recommend to the Council that the Council annually designate at its December meeting the Chairman of the AMA Delegation for the following year.

MAG Tax Notice Data

Chairman of Council, J. G. McDaniel, gave general information on the tax situation of MAG concerning the City of Atlanta and Fulton County. This report was received for information.

1960 AMA Annual Meeting Contribution Rebate

Eustace Allen, Senior AMA Delegate, presented a communication from the Florida Medical Association enclosing a check for \$300.00 as a refund on the MAG contribution made to the AMA and further that this \$300.00 rebate be returned to the Association's general fund.

MAG Furniture Salvage

Mr. Krueger reported on an inventory taken of furniture left in the former MAG offices in the Academy of Medicine. Mr. Krueger reported that five items from this inventory would be beneficial to MAG to bring to its new Headquarters Office Building for continued use. Executive Committee members then discussed the best way of disposal for the other items of furniture to the Fulton County Medical Society for their use in their building and further that the Fulton County Medical Society be so notified officially by the MAG Secretary.

AMA Annual Public Relations Institute

Mr. Krueger presented an invitation from the American Medical Association for MAG participation in the AMA Annual Public Relations Institute, September 1-2, 1960, Chicago. Mr. Krueger also reported that one day prior to this meeting the Medical Society Executive Association was holding their 1960 Institute for Medical Society Management. On motion duly made and seconded it was voted to send Mr. Krueger to both the MSEA and AMA meeting August 31 and September 1-2, 1960, Drake Hotel, Chicago, Illinois, and the expenses to be charged to MAG office travel.

Building Committee Report

Secretary John T. Mauldin described the items of furniture purchased by the Association for its new MAG Headquarters Office Building. This report was approved and received for information.

MAG Monthly Budget Report

Virgil B. Williams, Chairman of the Council Finance Committee, gave the monthly budget report on income disbursements of the Association. On motion (Williams-Hatcher) it was voted that the Executive Committee recommend to Council that the Building Depreciation and Major Repair fund be invested in Savings & Loan or some similar safe interest bearing security. It was also recommended that funds above operating funds be invested in short-term securities after investigation by the Treasurer with the recommendation of the Finance Committee and subject to the approval of Council. On motion duly made and seconded the monthly budget report was approved and accepted for information.

Legislative Committee Report

Eustace Allen presented a report on present national legislation concerning health care of the aged matters. The report was approved and accepted for information.

Troup County Medical Society Pension Request

Secretary Mauldin presented a letter of July 15, 1960 from Troup County Medical Society's President R. S. O'Neal which requested the Association to contribute \$50.00 per month, matching a like contribution from the county medical society for one of its members. On motion (Simonton-Mauldin), it was voted to approve the expenditure of \$50.00 per month as matched by the Troup County Medical Society and further that such monthly payments from the Society be mailed to the Association and the Association mail the full amount of \$100.00 to the physician for which the fund is requested.

Date and Site of September Council Meeting

President Milford Hatcher read a telegram from Charles Brown informing the Council that it would be impossible to meet as previously planned at Highland, North Carolina. On motion (McDaniel-Allen), it was voted to meet October 1-2, 1960 at the King and Prince Hotel, St. Simmon's Island, Georgia.

August Executive Committee of Council Meeting

By general agreement it was approved that the Executive Committee of Council of MAG meet Sunday, August 28, 1960 at 10:00 A.M. at the MAG Headquarters Office, Atlanta.

Poison Control Advisory Committee Appointment

President Hatcher presented a letter from C. S. Pittman in which Dr. Pittman requested that he not continue to serve on the Public Health Department Poison Control Advisory Committee. By general agreement it was recommended that Dr. Hatcher make this appointment at his discretion. President Hatcher also presented a letter from Simone Brocato in which Dr. Brocato requested to be replaced on the MAG Public Service Committee due to the pressure of other duties. This matter was referred to the August Executive Committee meeting for appointment.

AMEF Awards

Mr. Krueger presented American Medical Education Founda-

tion awards to designated county medical societies whose contribution was made by 100 per cent of the membership. Mr. Krueger sought the best method of distribution and by general agreement it was voted that the Councilor of the district in which the medical society was located should be responsible for the presentation of this award at the county society's next regular meeting.

Headquarters Office Report

Mr. Krueger reported on the status and activity of the Headquarters Office and discussed personnel problems with the members of the Executive Committee. He stated that the recent illness of Secretary Jane Cotter necessitated her replacement. This report was received for information.

Unfinished and New Business

J. G. McDaniel cited an article in the *Methodist Quarterly* concerning the American Medical Association. The article was detrimental to the profession in that it cited the AMA as a decaying moral influence in America. By general agreement, it was recommended that President Hatcher reply to this letter and so notify the AMA. It was further recommended that the Nashville, Tennessee County Medical Society be alerted to this article so that they might also have the opportunity of replying.

There being no further business, Chairman Hatcher adjourned the meeting at 6:30 P.M.

MAG HOSPITAL RELATIONS COMMITTEE MEETING

THE MEDICAL ASSOCIATION of Georgia Hospital Relations Committee was called to order by Chairman David Henry Poer at 10:45 A.M. on Sunday, July 24, 1960, at Fred Simonton's Farm, Centralhatchee, Georgia.

Committee Members and guests in attendance at this meeting included: David Henry Poer, Atlanta; John T. Mauldin, Atlanta; Walter Brown, Savannah; Rafe Banks, Gainesville; Herbert Tyler, Thomaston; W. Loomis Pomeroy, Waycross; Fred Simonton, Chickamauga; R. C. Williams, Atlanta; John L. Bowen, Atlanta; Mr. James Sitton, and Mr. M. D. Krueger.

Chairman Poer called on Mr. Krueger who read the minutes of the Hospital Relations Committee meeting of January 10, 1960 and on motion duly made and seconded these minutes were approved as read.

Hospital Indigent Care Program

Dr. Simonton and Mr. Sitton explained the Hospital Indigent Care Law as passed by the Georgia General Assembly in 1957. Mr. Sitton specifically explained the mechanics of administering the "HIC" Law and the coordination of this act with other programs. By general agreement it was recommended that the MAG Council, at the urging of its Hospital Relations Committee, send a resolution to the Governor of the State of Georgia for action on the implementation of the "HIC" Law. It was further suggested that the MAG contact the Association of County Commissioners on this matter, stimulate the County Commissioners of the larger counties to talk to the Commissioners of the small counties, and stimulate the county welfare people to talk to their own county commissioners so that this "HIC" program may be implemented in a successful manner.

It was further recommended that a sub-committee of the Hospital Relations Committee meet with Dr. Venable, Director of the State Department of Health, at some future date to discuss the implementation of the "HIC" program. Chairman Poer appointed John T. Mauldin, Fred Simonton, and R. C. Williams

to this sub-committee of the Hospital Relations Committee dealing with "HIC" law.

Georgia League for Nurses

The Council of the Medical Association of Georgia referred a letter from the Georgia League for Nursing to the MAG Hospital Relations Committee. This letter requested the appointment of a member of MAG to an advisory board for the Georgia League. On motion duly made and seconded it was voted that a MAG member to serve in this capacity be appointed by the Council and further that the Hospital Relations Committee recommends the appointment to such an advisory post for David Henry Poer or Joseph Mercer.

It was further recommended that the MAG appoint representatives to all nursing organizations in Georgia, when such is requested.

Paramedical Recruitment

Walter Brown reported on the Association's plans, programs, and problems in the field of paramedical recruitment. After general discussion of this report, on motion (Brown-Pomeroy) it was voted that a letter be written to the president of each county medical society requesting him to appoint a physician in that society to be in charge of paramedical recruitment and cooperate in the staging of "Career Days" at the high schools in his county. The motion also suggested the use of the AMA kit material of paramedical careers for use at "Career Days" in high schools. It was also suggested that the Auxiliary to the Medical Association of Georgia make similar appointments in the county medical society auxiliaries and Chairman Poer appointed P. W. Warg, Athens, to head the sub-committee on paramedical recruitment.

Hospital-Medical Council

John T. Mauldin, Chairman of the Hospital-Medical Council reported on the background of the Council and gave data on its present activity. He described in detail the under 25-bed accreditation program for smaller hospitals as sponsored by the Hospital-Medical Council. On motion (Pomeroy-Simonton) it was voted to commend Dr. Mauldin and the Hospital-Medical Council on the activation of this program and to send a copy of this commendation to the Council of MAG. It was further requested that material on the program be furnished to Dr. Simonton for possible publication in the AAGP journal, "GP."

Hospital Advisory Council

Mr. James Sitton explained the function, purpose, and scope of the new Hospital Advisory Council to the State Department of Health. He stated that this new Council combined the Health Indigent Care Committee, the Hospital Licensure Advisory Committee, and the Hill-Burton Advisory Committee. MAG representatives on this new Council are W. Loomis Pomeroy, Rafe Banks, and A. B. Conger. It was suggested that Miller Byne, Chairman of the State Board of Health Committee on Hospitals meet with the new Hospital Advisory Council members on the next Wednesday night meeting prior to the State Board of Health meeting on the following Thursday. Chairman Poer appointed Drs. Pomeroy and Banks to a sub-committee on Hospital Advisory matters and requested that the MAG Council appoint A. B. Conger to the Hospital Relations Committee so that he might also be on the Hospital Relations sub-committee as named above.

Other Business

General discussion ensued concerning new problems and prospects of the future. Mr. James Sitton outlined the health councils being formed by communities over the state to concern themselves with community needs as initiated by the State Department of Health. There were also discussions on the provisional license permits and the nursing home problems in caring for the aged.

On motion duly made and seconded, W. Loomis Pomeroy was appointed vice-chairman of the MAG Hospital Relations Committee. By general agreement it was recommended that the next meeting of the Hospital Relations Committee be held prior to November, 1960 at the discretion of the Chairman and the Executive Committee of the Hospital Relations Committee. By unanimous action the Hospital Relations Committee members expressed their sincere appreciation to Fred Simonton for his hospitality on the occasion of this meeting. There being no further business the meeting was adjourned at 1:15 P.M.

GEORGIA UROLOGICAL ASSOCIATION MEETING

REPORT OF THE Georgia Urological Association Section Meeting held in Columbus Georgia, May 1, 1960, and May 2, 1960.

SOCIAL: Cocktail hour at the home of Dr. and Mrs. T. H. Edwards, plus the combined efforts of Columbus urologists, Dr. Elisha J. Cain, Dr. W. P. Jordan, and Dr. J. L. Stapleton. This was a delightful party enjoyed by the urologists and wives, plus many guests from over the State, and Dr. W. F. Leadbetter of Boston, Massachusetts.

BUSINESS MEETING: The President, Dr. Robert McAllister, presided. The question of a four day Cruise for the fall meeting was referred to the incoming President, Dr. Charles Eberhart. New members: Dr. Brandes, Dublin; Dr. Waldrep, Rome. New officers: President Elect, Dr. Mark Whitehead; Executive Committee, Dr. J. Z. McDaniel; Secretary-Treasurer, Dr. David C. Williams, Jr. There was no further new business. The meeting was adjourned.

SCIENTIFIC SESSIONS: Navy Class Room, 2:30 P.M. — Diagnosis and treatment of some Pediatric Urological Problems, Dr. Weyland F. Leadbetter, Boston, Massachusetts. This was a truly most interesting and well documented paper that presented a sound basis of handling pediatric urological problems of reflux. He then briefly discussed the use of ileal conduction for preservation of upper urinary tract. After a brief intermission Dr. McAllister acted as moderator of a pyelogram conference. Pyelograms of interest were presented by Dr. T. H. Edwards, and Dr. Irvin Victor.

GUESTS: Dr. William D. Henderson, Eugene Talmadge Hospital, Augusta; Dr. James Sullivan, University Hospital, Augusta and Dr. Griffin, Macon.

MEMBERS ATTENDING LUNCHEON: Dr. W. P. Jordan, Columbus; Dr. T. H. Edwards, Columbus; Dr. J. L. Stapleton, Columbus; Dr. E. J. Cain, Columbus; Dr. Ernest Corn, Macon; Dr. Thomas Cowart, Atlanta; Dr. Rafe Banks, Gainesville; Dr. Irvin Victor, Savannah; Dr. Henry K. Jarret, Tifton; Dr. Robert McAllister, Macon; Dr. M. A. Hubert, Athens; Dr. Peter Brandes, Dublin; Dr. Rudolph Bell, Thomasville; Dr. Charles Reiser, Atlanta; Dr. J. Z. McDaniel, Albany; Dr. Harold McDonald, Atlanta; Dr. W. E. Upchurch, Atlanta; Dr. David C. Williams, Jr., Augusta; Guest, Dr. James Sullivan, Augusta; Guest, Dr. William Henderson, Augusta; Dr. Ben Baskinski, Macon; Dr. Lamar King, Griffin; Dr. M. H. Bennett, Atlanta; Dr. Mark Whitehead, LaGrange; Dr. A. K. Schmidt, Marietta; Dr. J. Gary Palmer, Marietta; Guest, Dr. Griffin, Macon; Dr. Charles Eberhart, Atlanta.

Our group wishes to express our gratitude to the Columbus people and the State Association workers for such a delightful meeting.

ATTENTION PHYSICIANS FILING MEDICARE CLAIMS

**Consult MEDICARE DIRECTIVE XII
for help on completing
Medicare claim forms.**

A directive has been mailed to all physicians. If you did not receive this directive write:

**Medical Association of Georgia
Medicare Department
938 Peachtree Street, N.E.
Atlanta 9, Georgia**

NEW MEDICAL LICENSES ISSUED

THE FOLLOWING have been licensed in Georgia by reciprocity, effective June 10, 1960:

License No.	Name and Address
9005	Jesse Earl Adams, Jr. 301 Medical Arts Bldg., Chattanooga, Tenn.
9006	William Lester Adcock, Jr. 933 Lambeth Cir., Durham, N. C.
9007	Theodore Marcel Avellone 3290 Mt. Gilead Rd., S.W., Atlanta 11
9008	Carl Lumpkin Beard, Jr. 515 McAllister, Greenville, Miss.
9009	John Mickle Brewer, Jr. 303 Medical Arts Bldg., Atlanta 3
9010	James Robert Carey 2882 Hillwood Ter., Atlanta 19
9011	Charles Robert Clark Lookout Mountain, Tenn.
9012	Joel Dewitt Conner 320 Ash St., Laurel Bay, S. C.
9013	William Thomas Creel 1117 16th Ave., Columbus
9014	Thomas H. Curtis Suite 523, Doctors Bldg., Chattanooga 3, Tenn.
9015	Robert Durlay Dean 129 Colonial Cir., Jackson 6, Miss.
9016	Carlos Ramon Del Busto 52 West Chicago Ave., Chicago 10, Ill.
9017	Carlos R. Duarte 2295 Amber Way, Decatur
9018	Patty S. Duarte 2295 Amber Way, Decatur
9019	Donald Henderson Eckles 1010 Stanton Dr., North Augusta, S. C.
9020	William Clark Ferrell 4882 Lorece, Memphis, Tenn.
9021	Samuel Earl Forbis, Jr. 2158 Bayswater Rd., Macon
9022	Robert Earl Froelich 1606 Winter St., Augusta
9023	Zachariah Walter Gramling, Sr. 705 Woodlawn Ave., North Augusta, S. C.
9024	Conrad P. Grossman 1050 Ponce de Leon Ave., Atlanta
9025	Newell McAfee Hamilton Box 345, Grady Mem. Hospital, Atlanta 3
9026	Alfonso Hudson Holquin, Jr. 4120 Peachtree Rd., N.E., Apt. 8F, Atlanta
9027	Jay Richard Johnson Duke University Hospital, Box 2962, Durham, N. C.
9028	Beverley Bryan Jones 1611 N.W. 14th Ave., Miami 35, Fla.
9029	James Marvin Kelley, Jr. 2721 Brown Ave., Durham, N. C.
9030	Robert Gary Kiger 3335 Tanglewood Dr., Augusta
9031	Dixon Alexander Lackey, Jr. 305 E. Ponce de Leon, Apt. C-1, Decatur
9032	Marion Elizabeth Moore McCroskey 2579 Dellwood Dr., N.W., Atlanta 5
9033	Robert Lee McDowell 1326 Gordon St., S.W., Atlanta 10
9034	Reinaldo R. Menendez 106 Carroll Dr., Houston, Miss.
9035	Marilynn Lucile Miles 1296 Garner Ave., Schnectady 9, N. Y.
9036	Robert Carr Moffatt 1334 Cardinal Dr., Nashville, Tenn.
9037	Zebulon Vance Morgan, Jr. 520 Church St., Decatur
9038	Fred William Payne, Jr. Dept. of Surgery, Talmadge Mem. Hospital, Augusta
9039	Hans Juergen Peters 2834 Cornelia Rd., Augusta
9040	Hubert Osteen Platt 2007 Canary Lane, North Augusta, S. C.
9041	William Lee Pritchard 1048 Katherine St., Augusta
9042	Donald Wilson Rairigh 3166 Parkridge Cresc., Chamblee
9043	Sterling J. Ritchey 98 General Hospital, APO 34, New York, N. Y.
9044	Marvin David Siegel 370 Alberta Ter., N.E., Atlanta 5
9045	Robert King Smith 202 Chanute Rd., Goldsboro, N. C.
9046	Gordon Oeola Stafford 1106 N. Fairground St., Marietta
9047	James Robert Teabeaut, II Medical College of Georgia, Dept. of Pathology, Augusta

NEW LICENSES / Continued

License No.	Name and Address
9048	William Elmer Tryon 4 Catawba St., Spartanburg, S. C.
9049	J. Bernard Vick 64 C Galveston Pl., S. W., Washington 24, D. C.
9050	Cecil Dixon Warren 112 Indiana Ave., Athens
9051	William Spurgeon Warr The Medical Center, Columbus
9052	John D. Whitnack 101 3rd St., Atlanta
9053	James Christopher Wright Elfin Rd., Lookout Mountain, Tenn.
9054	Edward Holbrook Wyman Atlantic Coast Line Hospital, Waycross
9055	Herman Sigmand Zeve 702 Stiles Ave., Savannah

The following have been licensed in Georgia by examination, effective July 22, 1960:

9057	Russell Arch Acree 121 Courtland Dr., Augusta
9058	Earl Lewis Alderman c/o Mrs. J. H. Chandler, 930 Seiler Ave., Savannah
9059	Stanley Preston Aldridge 2069 Yucca Lane, Decatur
9060	Lawrence Lanier Allen Country Club Rd., Valdosta
9061	James Anderson 3013 Randolph St., Jackson, Miss.
9062	John Lee Anderson, Jr. Spring Valley Rd., R.F.D. 3, Athens
9063	John Robinson Andrew c/o J. R. Smith, Hill St., Milstead
9064	James Davenport Armistead 20 Dantzler Dr., N.E., Atlanta 22
9065	Joseph Allan Arnold 1126 N. Highland Ave., N.E., Atlanta 6
9066	James Eli Averett, Jr. 2493 Williams Lane, Apt. No. 1, Decatur
9067	Ivan Arnold Backerman 807 Church St., Decatur
9068	Albert Glenn Bailey Blue Ridge
9069	Marvin Israel Baker 838 Old Grove Manor, Jacksonville 7, Fla.
9070	Larry Turner Ball 2072 A Sylvan Cir., S.W., Atlanta 10
9071	Thurml L. Banks 1500 7th Ave., San Francisco, Calif.
9072	George Edward Batayias 336 E. 54th St., Savannah
9073	Martin Luther Beard 100 E. 5th St., Hattiesburg, Miss.
9074	Thornton Arnold Beckner 235 N. 9th Ave., Jacksonville Beach, Fla.
9075	James Louis Becton 5 Symons St., Pooler
9076	John Thomas Bigger, Jr. 1215 Johns Rd., Augusta
9077	Billy Ray Blakey 215 Celia Lane, Orlando, Fla.
9078	James Laval Bland Box 421, Sylvania
9079	James Walter Bland, Jr. 93 Sheridan Dr., N.E., Apt. 3, Atlanta 5
9080	Joseph Randall Bobo, Sr. 991 39th Ave., N., Nashville, Tenn.
9081	Robert Martin Boger 1511 O'Neal Pl., Apt. 4, Decatur
9082	James Ben Boorstin 1648 Briarcliff Rd., N.E., Atlanta
9083	Charles H. Dixon Bowers, Jr. 2207 Louisiana Ave., New Orleans, La.
9084	Robert Arnold Bowman 846 E. 167th St., New York, N. Y.
9085	Thomas Sidney Branigan Box 53, Lafayette
9086	James N. Brawner, III 262 W. Wesley Rd., N.W., Atlanta 5
9087	Vann Allen Brewster 812 S. Main St., Cedartown
9088	Lloyd Clifford Brewton 829 Peachtree St., Louisville
9089	Thomas Paul Briant 2295 Eastway Rd., Decatur
9090	James Clowney Brice, Jr. 681 Cherry St., N.W., Atlanta 13

License No.	Name and Address
9091	David Bridgeford, III 3010 Lake Dr., Durham, N. C.
9092	Glenn Jackson Bridges, Jr. 196 17th St., N.E., Atlanta
9093	James Wilson Bridges 2770 N.W. 43rd Ter., Miami, Fla.
9094	William Jesse Briggs, III 244 Eureka Dr., N.E., Atlanta 5
9095	James Odell Brookins 4201 29th St., Tampa 5, Fla.
9096	Alvin Montero Brown 2225 Murphy Ave., c/o Vann, Nashville, Tenn.
9097	Charles Edwin Brown Rte. 2, Box 100, Bainbridge
9098	Walter John Brown, Jr. 2624 Hazel St., Augusta
9099	Winston Murphy Bryant, Jr. 2700 High St., Portsmouth, Va.
9100	Charles Keene Bultman 307 Bartlette St., Sumter, S. C.
9101	James Edmond Burns 610 Forrest Rd., Columbus
9102	Walter Howell Butler 3428 Ridge Ave., Macon
9103	James Allen Butts 1707 N. Decatur Rd., Atlanta 7
9104	Calvin Lee Calhoun 429 Rock St., Atlanta
9105	Grant Perry Carmichael 3112 Sharon Dr., Macon
9106	Robert Alfred Carter Lake Park
9107	Cecil David Cason Rte. 3, c/o Mrs. W. F. Dean, Sr., Rockmart
9109	Roy Gerald Chambers Rte. No. 4, Cleveland
9110	James Bethel Chandler, Jr. Rte. No. 1, c/o Moline Ellis, Hull
9111	Donald Leveritt Chatman 311 S. 13th St., Baton Rouge, La.
9112	Horace Delbert Christian Box 374, Institute, W. Va.
9113	James Edward Clark 59 Sheridan Dr., N.E., Apt. 7, Atlanta 5
9114	John Franklin Cluxton 3625 Hedrick St., Jacksonville, Fla.
9115	Henry Wickline Coe 1534 Shoup Ct., Apt. 2, Decatur
9116	Paula Faye Conaway 231 Beverly Pl., Macon
9117	James Fenimore Cooper 1618 Pulaski St., Baltimore 17, Md.
9118	Robert James Corliss Veteran's Adm. Hosp., Atlanta
9119	Randall Epps Couch 130 Barrow St., Athens
9120	Glenn Dale Crawford P.O. Box 815, Emory University, Atlanta 22
9121	Charles Joseph Crist 762 55th Ave., S. Petersburg, Fla.
9122	Calvin Horace Curry, Jr. 121 N. Duval, Quincy, Fla.
9123	Raymond Cutts, Jr. 2415 Jefferson St., Apt. A-1, Nashville 8, Tenn.
9124	David Althonya Danley 2175 14th Ave., S. St. Petersburg, Fla.
9125	Frank Buvard Davis 3050 Webster Ave., San Diego 13, Calif.
9126	Jordan Kent Davis 1924 9th Ave., S., Birmingham, Ala.
9127	Carol Marlene Deloatch Rte. 1, Box 56, Pendleton, N. C.
9128	Edith June DeZoort 4610 Abercorn St., Savannah
9129	Spencer Cooler Disher, Jr. 114 Reid St., Darlington, S. C.
9130	Lewis Clinton Downing 912 7th St., N.W., Roanoke, Va.
9131	Alan Ronald Eckels 4731 Crescent St., Jacksonville 5, Fla.
9132	Martin Luther Edwards, Jr. 1014 Villa Pl., Nashville 12, Tenn.
9133	Saul Eisen 221 Academy Ter., Linden, N. J.
9134	John William Flynt, Jr. 1821 W. Anderson Ave., Atlanta 14
9135	Edward Shelby Forrester, Jr. Leesburg
9136	Telezee Littlejohn Foster 507 E. Frederick, Box 157, Gaffney, S. C.

License No.	Name and Address
9137	Cyler Duggan Garner 3199 A Brookwood Dr., Macon
9138	Luis Geerken 653 Clifton Rd., N.E., Atlanta 7
9139	Alma Rose George Box 316, Mound Bayou, Miss.
9140	William Arthur German 1020 16th Ave., N., Nashville 8, Tenn.
9141	Clarence Arnold Gilmore 1100 Tenth St., West Palm Beach, Fla.
9142	Milton Stanley Goldman 1500 Kay Lane, N.E., Atlanta 6
9143	Theodore Napoleon Graham 3039 Holcomb, Detroit 14, Mich.
9144	James Robert Gray 1655 Arrowhead Trail, N.E., Atlanta 6
9145	Mack Varnedoe Greer P.O. Box 146, Homerville
9146	William Vivian Griffin, III 593 Whitefoord Ave., N.E., Atlanta
9147	Peter Robert Gross 1570 Memorial Dr., S.E., Atlanta
9148	Robert Hamilton Groves 102 Martha St., Albany
9149	Alex Kramer Gup 1035 W. Wesley Rd., N.W., Atlanta
9150	Elaine Langdon Hajosy Rte. 3, Cedartown
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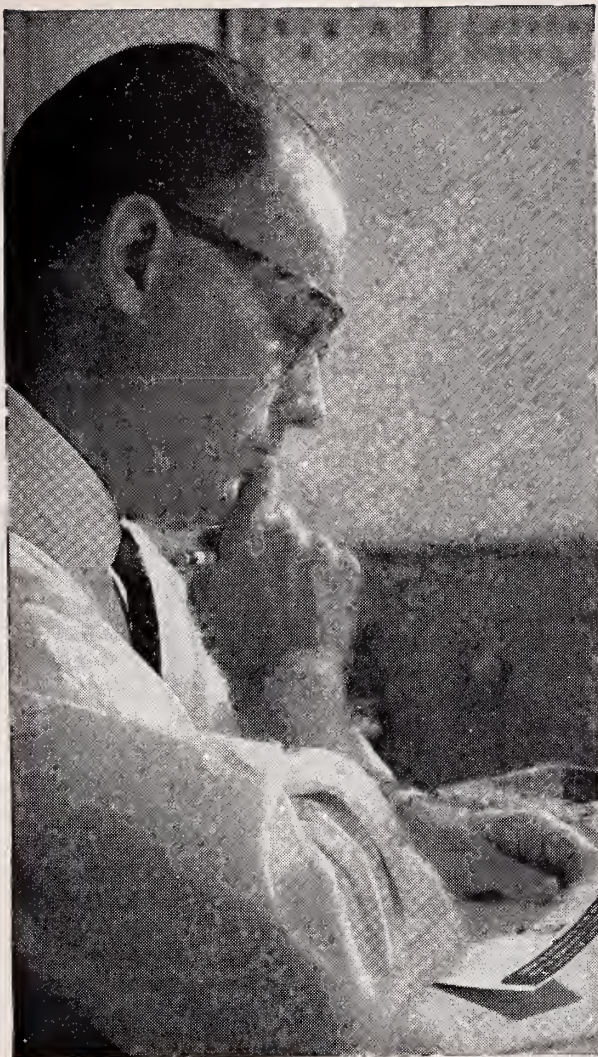
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THE CLINICAL SIGNIFICANCE OF THE ELEVATED SERUM AMYLASE

J. H. Hilsman, M.D., *Atlanta*

There exists doubt not only as to the diagnostic value of the test itself, but also doubt as to the significance of the degree of its elevation.

THE ELEVATION OF the amylase in the blood of a patient with abdominal pain has been thought to be indicative, if not actually diagnostic, of acute pancreatitis.¹ However, there are several reports^{2,3,4,16} indicating that an elevated serum amylase is not a dependable sign of pancreatitis nor is it pathognomonic of that condition. It has also been said¹ that the reliability of the test is not what it is purported to be. Consequently, in any given patient with abdominal pain and an elevated amylase value in the blood, the actual clinical significance of the test is unknown.

Purpose

The purpose of this report is to determine the diagnostic accuracy of the elevated serum amylase test in a series of unselected patients, all of whom had abdominal pain to some degree and elevated amylase in the blood. By the determination in the study of this group of the incidence of extra-pancreatic disorders, some insight into the clinical significance of the elevated amylase value can be reached.

Review of the Literature

In a recent review of the pancreas⁵ the statement is made that the serum amylase level has proved to be a great help in the diagnosis of acute pancreatitis. Priestley⁶ has indicated, too, that the elevated serum amylase constitutes the most valuable diagnostic finding in an acute attack of pancreatitis. The study by Fogerson and Shedd,⁷ in 1955, of 74 cases

of acute pancreatitis indicated in their experience that, although the serum amylase is elevated in other conditions, it tends to rise later in these other conditions and is not as high as in acute pancreatitis.

In agreement, Warren⁸ states that an elevation of the serum amylase to two or three times the normal value is indicative of acute pancreatitis. Another author⁹ indicates that the height of the serum amylase enhances its usefulness. In a series¹⁰ of 350 consecutive patients with acute abdomens, 14 of which were due to pancreatitis, the serum amylase by the starch iodine method was above 1,000 units in 12. The other two patients had moderate amylase elevations. Only seven of the 14 cases were confirmed, however, by laparotomy and only one by necropsy.

On the other hand, it is known that an elevation of the amylase in the blood can occur in many various conditions, extra-pancreatic as well as pancreatic. In addition to acute pancreatitis, the serum amylase has been reported to be elevated in acute cholecystitis,⁴ ectopic pregnancy,¹¹ alcoholism,¹² perforated peptic ulcers,³ small bowel obstruction,¹³ uremia,¹⁴ mesenteric thrombosis, extra-abdominal trauma,² and other non-pancreatic diseases.¹⁵ These reports basically indicate that in pancreatitis, as in other conditions, there may be an elevation of the serum amylase. They give no indication as to the reliability that may be placed upon the amylase elevation in any unknown patient or groups of patients. The height of the amylase elevation is controversial, also, as some⁹ feel the higher amylase values are more useful in indicating pancreatitis, whereas others¹ feel that the high amylase values are more apt to indicate acute cholecystitis and that elevations of the serum amylase above 500 Somogyi units per

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100 ml. may occur in the absence of pancreatic disease. Therefore, there exists doubt not only as to the diagnostic value of this test itself,^{10,1} but also doubt as to the significance of the degree of its elevation.

Procedure

With these doubts and differences of opinion in mind, this study was undertaken to determine the diagnostic accuracy of the elevated serum amylase insofar as it reflects proven pancreatitis. It was hoped to be able to estimate the clinical accuracy of this blood test by comparing the incidence of proven pancreatitis in a group whose diagnoses has been established with the incidence of suspected pancreatitis in a similar group whose diagnoses had only been reached by clinical impression.

All the serum amylase determinations obtained from the laboratory records of the past year of five Atlanta hospitals were reviewed. The upper limits of normal do not exceed 200 units in any of these hospitals. The basic Somogyi technic¹⁷ of starch hydrolysis is used, but either the starch iodine method, the turbidometric method, or Nelson's modification technic are used to measure the reducing substances released. The starch iodine method seems to give higher values than those obtained by the other methods, as most of the highest values came from one hospital that used the starch iodine method, and seven out of the eight values over 2,000 units were measured by this method. It is felt, then, that all values above 400 units were significantly elevated for study. These cases were then evaluated by the study of each chart. Sixty-seven cases were so compiled with charts, complete enough to be able to determine the clinical, pathological, or surgical explanation for the cause of each serum amylase elevation. These 67 cases form the basis for this report. The amylase values range from 400 units to a high of 11,000 units. All specimens were drawn early in

each hospital course and in those cases with more than one determination, the highest value was used. All cases had the common denominator of abdominal pain of some degree, a significantly high amylase level, and suspected acute pancreatitis.

Results

In 42 cases (Table 1) the diagnoses had been reached by clinical impression. These patients had been conservatively treated and had recovered. Twenty-seven of these 42 patients had had negative or no diagnostic studies, whereas the remaining 15 had had positive diagnostic studies suggestive of either pancreatic or extra-pancreatic disorders or both.

In the remaining 25 cases (Table 2), the final diagnoses had been proven, either at laparotomy or at autopsy. Fifteen cases were operated upon and did well, although within six months two of these had died. Three were found to have had trauma to the pancreas and two had biliary tract disease with pancreatitis. One patient had acute cholecystitis without surgically estimated pancreatic inflammation. Two patients had carcinoma of the head of the pancreas (and subsequently died) and one had a perforated ulcer without pancreatic penetration. Six cases had acute cholecystitis and/or common duct obstruction, but no mention was made in the operative notes as to the status of the pancreas.

Ten patients came to autopsy; five of these 10 cases had, in addition to other conditions, acute pancreatic inflammation with necrosis or hemorrhage. The other five patients had other conditions, too, (intestinal obstruction, staphylococcus abscess in the lesser sac, uremia, acute cholecystitis, and intestinal perforation) with no pancreatic inflammation, although the patient with acute cholecystitis had a mild interstitial pancreatitis.

Discussion

With Bernard's statement¹ in mind that the diagnosis of acute pancreatitis cannot be ascertained in

CLINICAL DIAGNOSES	NEGATIVE STUDIES CONSERVATIVE R _x RECOVERED	POSITIVE STUDIES CONSERVATIVE R _x RECOVERED
ALCOHOLICS	7	
TRAUMA	1	3
BILIARY TRACT DISEASE		11
NON PANCREAS DISEASES	2	
ACUTE PANCREATITIS	17	1
TOTAL	27	15

Table 1: Unproven (clinical) diagnoses of 42 patients with abdominal pain, elevated amylase values, and suspected pancreatitis.

CLINICAL DIAGNOSIS	NEGATIVE STUDIES CONSERVATIVE R _x DIED - AUTOPSED		OPERATIVE TREATMENT - RECOVERED		
	PANC.	NON PANC.	PANC.	PANCREAS NORMAL	NO NOTE AS TO PANCREAS
ALCOHOLIC	4	1			
TRAUMA		1 (OPERATED)	3		
BILIARY TRACT DISEASE		1 *	2	1	6
NON- PANCREAS DISEASES		2		3	
ACUTE PANCREATITIS	1 (OPERATED)				
TOTAL	5	5	5	4	6

* Mild interstitial pancreatitis

Table 2: Proven diagnoses in 25 patients with abdominal pain, elevated amylase values, and suspected pancreatitis.

any series without examination of the pancreas at first hand, no estimate of the incidence of pancreatitis in the 42 patients whose diagnoses had been reached by clinical impression can be determined. However, in those 25 patients whose diagnoses had been established either at laparotomy or autopsy, there were nine with various conditions but without any major pancreatic inflammation. In addition, there were six more that came to surgery for biliary tract disease probably without major pancreatic inflammation, as the operators made no mention of the pancreas in the operative notes. This suggests that the operators considered the pancreas normal or not worthy of mention.

Therefore, nine, if not more, of the 25 proven cases had acute abdominal pain of some degree, high amylase values, and no major or established pancreatic inflammation. If this proven group had such a high incidence of extra-pancreatic conditions associated with high amylase values, the 42 unproven cases could well be suspected as also having an equal incidence of non-pancreatic disorders and as having been conservatively treated on the possibility of a high degree of error.

Some authors feel that the level of the amylase has some diagnostic value. Rightly or wrongly, it is felt that the higher the amylase in the blood the more likely is the diagnosis of acute pancreatitis. Others¹ hold an opposite view. The review of the amylase values in the series of proven cases with both pancreatic and extra-pancreatic disorders show a close relationship. The values of those with pancreatic disease range from 400 units to 2,000 units and those without pancreatic inflammation range from 403 units to 2,000 units. Again, it is noted that the values of 2,000 units in both subgroups were estimated by the starch iodine method. In Figure 1 the serum amylase values for both the pancreatic and extra-pancreatic groups are plotted and show an almost identical range. The six cases of biliary tract disease that came to surgery, but had no note as to the condition of the pancreas, are omitted.

This comparison suggests that the elevated amylase values in this study of the proven cases are not indicative of either an extra-pancreatic disorder or of pancreatitis, but of both. It suggests, too, that one elevated level is no more diagnostic than another. One high amylase value is just as apt to reflect acute pancreatitis as acute cholecystitis, or to reflect pancreatitis in an alcoholic as intestinal obstruction. The values in patients with uremia are of the same level as those with carcinoma of the head of the pancreas. The test then is not considered by itself reliable in determining the conservative treatment of the acute abdomen.

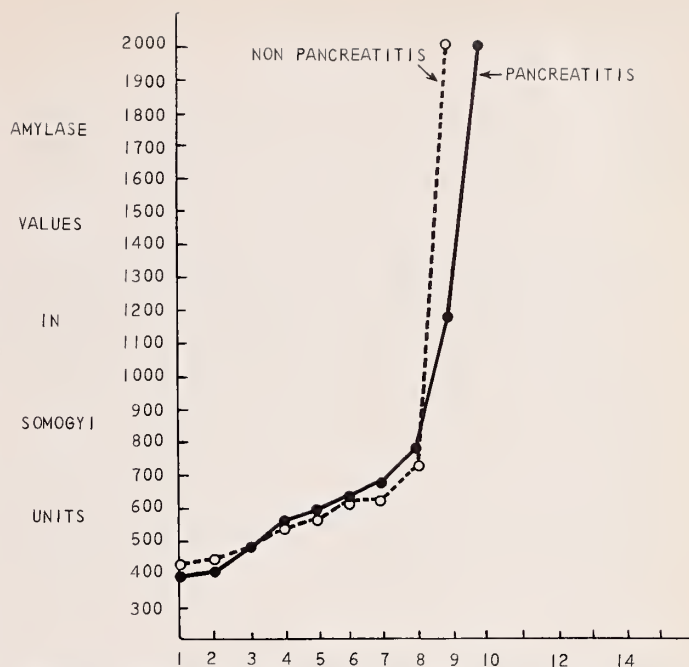


Figure 1: Comparison of the amylase values in those cases with proven pancreatitis and those without pancreatic involvement.

Summary

1. There are still differences of opinion as to the diagnostic reliability of the elevated amylase in the blood.
2. The incidence of extra-pancreatic disorders in 25 positively diagnosed patients with abdominal pain and elevated amylase values in the blood revealed nine such cases.
3. Comparison of the elevated amylase values in the positively diagnosed patients with both pancreatic and extra-pancreatic disorders showed a close relationship.
4. The high serum amylase value has little clinical significance and in itself is unreliable in making any specific diagnosis.

Conclusions

1. It seems reasonable to conclude that, if nine out of 25 patients with abdominal pain and elevated serum amylase had no major pancreatic inflammation, an equal incidence exists in the 42 cases whose diagnoses and conservative treatment were based on clinical impression.
2. Therefore, it is felt that the conservative treatment of the acute abdomen based on the serum amylase diagnosis of acute pancreatitis is probably subject to a certain and significant, but unknown, degree of diagnostic error.
3. The high serum amylase might even be considered as much of a liability as an asset in the clinical evaluation of abdominal pain.

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NATIONAL SURVEY INDICATES AGED ARE CAPABLE OF FINANCING THEIR OWN HEALTH CARE

THE AMERICAN MEDICAL ASSOCIATION reported recently that an independent national survey just completed by university sociologists "emphatically proves that the great majority of Americans over 65 are capably financing their own health care and prefer to do it on their own, without federal government intervention."

Dr. Leonard W. Larson, Bismarck, N.D., president-elect of the A.M.A., described the study as "uniquely important," and urged Congress to "devote immediate and careful study to the basic facts brought forth in the study" before reaching final decision on medical aid legislation for the aged.

"The study disproves some dangerous misconceptions about the aged," Dr. Larson said. "It shows that most of these citizens are in good health, not sick, and are in moderately good financial condition, not hardship cases."

The study was conducted by James W. Wiggins and Helmut Schoeck, director and associate director of the project. Both are members of the Department of Sociology and Anthropology of Emory University, Atlanta. The study was based on extended personal interviews among 1,500 non-institutionalized persons 65 years of age and over. The interviews were conducted by 100 trained interviewers under the supervision of professional sociologists, representing more than a dozen well-known American universities and colleges. Dr. Wiggins presented the first findings of the study before the Fifth Congress of the International Association of Gerontology at San Francisco, August 11.

In his statement discussing the results of the study, Dr. Larson emphasized these facts:

Sixty-one per cent of the people interviewed con-

sidered their health was good; 29 per cent thought it was fair, and only 10 per cent thought it was poor.

Ninety per cent could think of no personal medical needs that were not being taken care of. A relatively small percentage of those who said they did have medical needs attributed the failure to meet these needs to lack of money. Often they said they had decided against treatment on the grounds it was not worth the "risk or trouble."

Sixty per cent said that they now are covered by private voluntary health insurance.

Sixty per cent said that if they sold everything they owned, and paid all their outstanding bills, they would have more than \$7,500 left in their bank accounts.

Dr. Larson also cited the following question asked by the interviewers and the answers which they received:

"As you know, some people had not enrolled in a medical insurance plan, such as Blue Cross or Blue Shield, before they became 65 years old. What do you think would help such a person most?"

"Let people over 65 enroll—26 per cent."

"Establish new private medical insurance plan for people over 65—16 per cent."

"Federal government to set up medical insurance plan for people over 65 who want it—36 per cent."

"Federal government to set up medical insurance plan which everyone over 65 must buy—10 per cent."

"Don't know—12 percent."

"This demonstrates that the vast majority of our older citizens favor voluntary programs and that only 10 per cent or so support compulsory plans," Dr. Larson said.

POSTPARTAL HEART DISEASE

*Recovery seems to be the rule, although
chronicity and death may occur.*

Simone Brocato, M.D., *Columbus*

ALTHOUGH MENTIONED IN the earlier literature,^{1,2} it was probably the papers of Hull and associates^{3,4} which popularized the entity most commonly known as "Postpartal Heart Disease." And indeed, little but confusion has been added to their observations as recorded in 1937-38. An excellent review was published by Melvin⁵ in 1947. In spite of skeptical opinions,⁶ it has certainly been witnessed by enough qualified physicians to establish its existence.

The entity discussed here refers to congestive heart failure occurring only in the immediate postpartal period with no previous evidence of heart disease—either in the history, physical examination, or laboratory data—nor of conditions which result in myocardial involvement. It has been observed more commonly in Negroes, usually after the first pregnancy, and, in Hull's experience, more frequently in primipara, after multiple births and toxemia.

The clinical picture³ includes severe dyspnea, anasarca, mild systolic and diastolic hypertension, cardiomegaly, and a gallop rhythm. Peripheral embolization is extremely common. Other features noticed are a small pulse pressure, a poorly contracting heart, and an apical systolic murmur.

The roentgenograms show marked cardiac dilatation; severe pulmonary congestion and/or pleural effusions are common. The electrocardiograms in the experience of many are not characteristic, but in the author's cases (reported herewith and unpublished) are strikingly similar, showing generally inverted T waves with some ST segment depression.

The onset is generally from two to six weeks after parturition; in the author's experience, this is generally acute, but others have noticed it may be insidious. Many of the patients have no symptoms during pregnancy. Others will give the history of mild edema, dyspnea, and palpitation of normal pregnancy which completely disappear following delivery, only to return in a strikingly abnormal manner, and when they present themselves to the physician are found to be in marked congestive failure.

Pathogenesis Not Established

The pathogenesis has been widely discussed, but not established. Speculative etiological factors mentioned^{3,4} have been anemia, some unknown endocrine disorder, toxemia, glomerulonephritis, nutritional deficiency, cor pulmonale, and others—none of which in our present state of knowledge can be definitely implicated.

As stated, the existence of this condition as a clinical entity has been debated by some, and many of the cases in the literature create doubt in the minds of those who have not observed it. For instance, one or two of Woolford's⁷ cases seem to be compatible with cor pulmonale secondary to multiple emboli, and another of his "borderline" group had rheumatic valvular lesions. Meadow's⁸ cases included patients with chronic pyelonephritis, miliary tuberculosis, and obstructive nephropathy due to metastatic carcinoma. Benchimol⁹ divided his cases into five types, of which only one, group iii, i.e., "cases related to a non-specific myocarditis" belongs in the category being discussed here.

The pathology is interesting. The cardiomegaly

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POSTPARTAL HEART DISEASE / Brocato

is attributed mainly to cardiac dilatation. Antemortem intraventricular thrombi, usually attributed to stasis, inefficient ventricular contraction, and subendocardial degeneration, are found.¹⁰ Gouley, et al,¹¹ describe the microscopic changes as follows:

. . . The outstanding feature noted in the acute and subacute phases appears to be a disintegration of the myocardial fibers involving the nuclei to a lesser extent so that the latter remain as a conspicuous and often major element in the cellular collection that has replaced the myocardium. Hemorrhage into these areas is a rather common finding. A moderate number of lymphocytes and macrophages, occasional neutrophils and also eosinophils are present but the myocardial nuclei are found in practically every active lesion, indicative of a sarcoplasmic degeneration rather than an interstitial infectious inflammation. . . . As these lesions become older, they are invaded by fibroblasts, the original myocardial nuclei disappear, and ultimately acellular scars replace the lesion. . . .

Recovery seems to be the rule, although chronicity and death may occur.

Hull and Hidden categorize the condition to the above described clinical picture, limited by the following: (1) the presence of congestive heart failure with symptoms beginning within six months after the termination of a pregnancy; (2) absence of cardiac symptoms before the beginning of the pregnancy; (3) absence of a history of heart disease or of hypertension diagnosed before the beginning of pregnancy, and (4) lack of criteria (including x-ray and electrocardiographic signs) by which heart disease or other etiologic types may be diagnosed.

Perhaps if only such cases were gathered and carefully discussed, more information about the pathogenesis of this interesting entity could be obtained.

A brief report of three cases illustrating (1) an acute course; (2) chronicity, and (3) death, follows:

Case One

MRP, W-F-33, was admitted to Cobb Memorial Hospital in congestive heart failure on August 27, 1956 by Dr. Clyde Knowles and was responding to conventional therapy when seen by the author in consultation.

The patient had delivered twins uneventfully about one week prior, although two units of blood had been given for anemia.* There had been no cardiac difficulty through five preceding pregnancies and she had been healthy except for childhood measles and mumps. During this pregnancy no unusual dyspnea, palpitation, or other symptoms had been experienced. Just prior to delivery there was some "swelling" which cleared.

She did not appear ill. The fundi showed mild arteriolar spasm. The lung bases were dull to per-

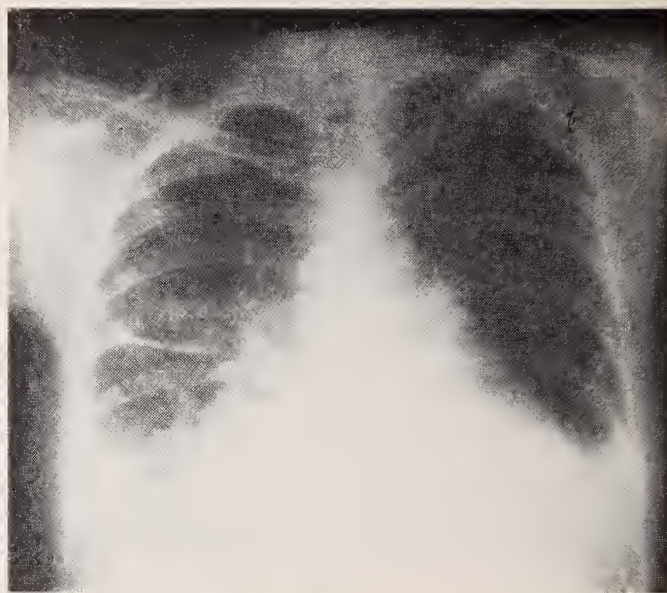


Figure 1: MRP, August 28, 1956.

cussion, with a few rales. The heart was enlarged, the rate 110. The BP was 152/120. Cardiomegaly and a protodiastolic gallop were present, but there were no paradoxical pulse, thrills, or murmurs. The liver, kidneys, and spleen were not palpable. A three-plus pedal edema was present. The hemogram was normal, with a WBC of 12,950. The urine had a specific gravity of 1.001 with a four-plus albuminuria.** The chest film confirmed the clinical findings of pleural fluid and cardiac enlargement. The EKG was abnormal (Figures 1 and 2).

She improved rapidly, but there appeared to be no specific response in tachycardia, gallop, etc. She was again seen at the office on October 13, 1956, and all clinical evidence of disease had disappeared except for residual changes in the x-ray and EKG (Figures 3 and 4).

***Albuminuria and low specific gravity, in this and other cases, proven to be secondary to the congestive failure itself.*

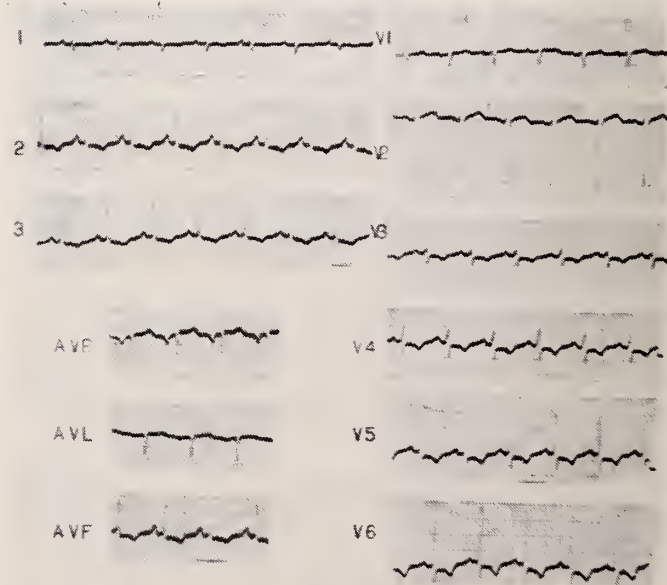


Figure 2: MRP, August 8, 1956. Right axis. Sinus tachycardia. T waves low or inverted. ST depression.

*Anemia, in this and other cases, difficult to evaluate in absence of data on plasma volume, total body water, and red cell mass.



Figure 3: MRP, October 13, 1956.

Case Two

ABF, C-F-18, entered the Medical Center on August 7, 1954; delivered spontaneously, and was dismissed on August 10. She had been regularly followed in the Clinic throughout a normal gestation, including monthly urinalyses, blood pressures, and a chest film. One month later, she was readmitted because of a "cold" of four days duration and a persistant cough, producing a blood-tinged sputum. At this time she was first seen by the author. She was acutely ill, with a BP 130/90, tachypnea, tachycardia, generalized pulmonary rales, cardiac enlargement, a gallop, and no mumurs. The hemo-gram was normal except for a WBC of 15,800. The urine contained a faint trace of albumin. (See Figures 5 to 10 for x-rays and EKG's). The rectal temperature was 102° on admission, 101° the next day, and normal thereafter. Remarkable improvement was observed during treatment for congestive heart failure and the patient was discharged.

She was subsequently hospitalized with the same



Figure 5: ABF, September 5, 1954.

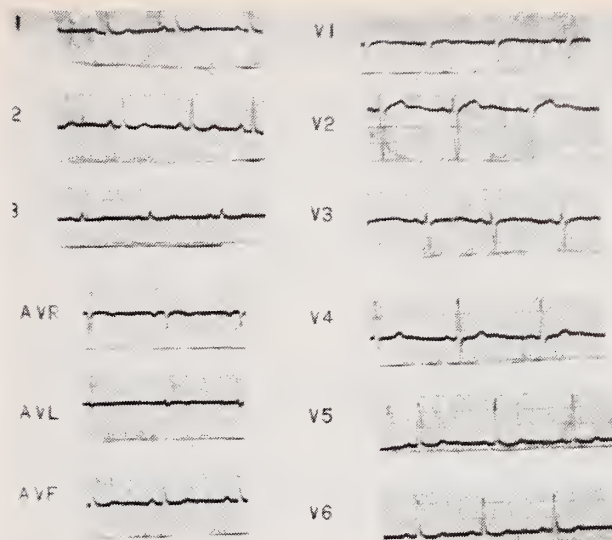


Figure 4: MRP, October 13, 1956. Abnormal changes have regressed markedly.

clinical picture from November, 1954 to January 15, 1955, February 18, 1955 to March 11, 1955, and from January 30, 1957 to February 14, 1957. Extensive diagnostic studies were frequently repeated by various house physicians.

In May, 1958, the patient reported to the Clinic, pregnant again. She was asymptomatic, doing house chores, and working regularly in a cafeteria. An asymptomatic gestation followed (under the author's observation) in spite of persistant cardiomegaly and a gallop, until August 20 when no evidence of fetal life was noted. A stillbirth occurred in the hospital on September 15, 1958. At the time of admission the respirations were 12, pulse 90, and BP 110/70. Five hours later the patient was found in shock with a brisk postpartal hemorrhage. Recovery was uneventful and she was discharged four days later and last seen on September 24, 1958. In February, 1960, she was called in for the preparation of this report;

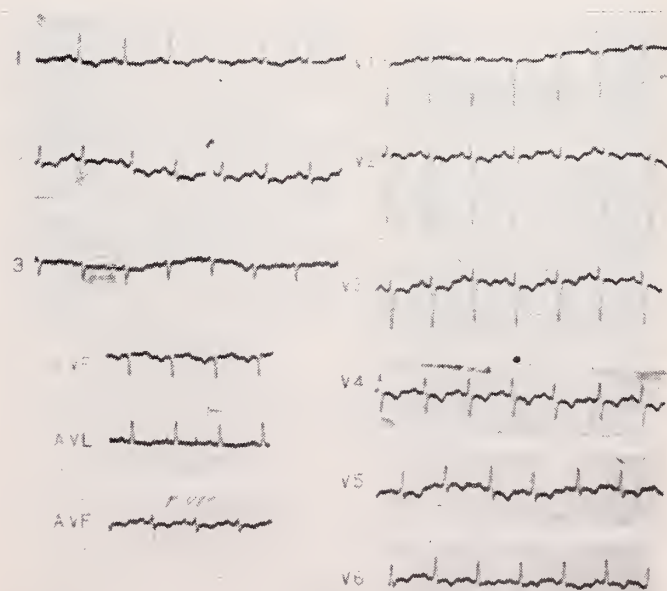


Figure 6: ABF, September 6, 1954. Note generalized T wave inversion and ST depression.

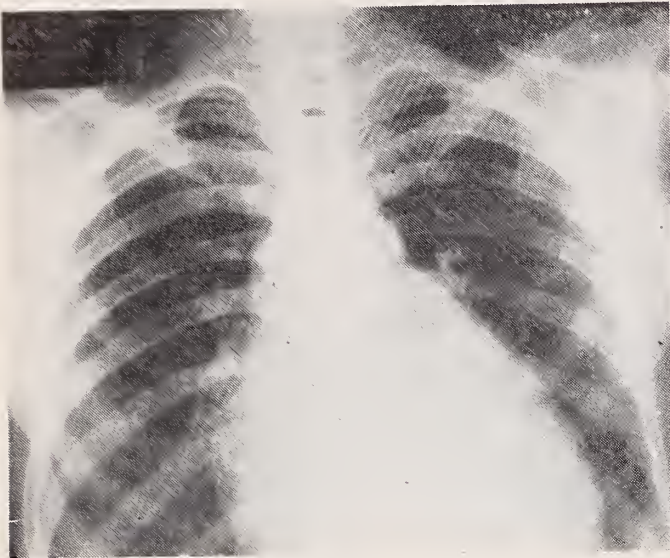


Figure 7: ABF, February 19, 1955.

asymptomatic, employed by the cafeteria, and taking no medicine. The gallop, cardiomegaly, and EKG changes were still present.

Addendum

* Since this paper was submitted, Patient ABF expired suddenly on August 17, 1960, while working at Ft. Benning. Autopsy was done by Albert C. Hunt, M.D., M.C., U.S.A. The heart weighed 460 gms. with normal valve measurements. The left ventricle averaged 2 cm. in thickness and the right, 5.6 mm. There were no lesions of the endocardial or myocardial surfaces and the valves were completely normal. The right lung weighed 610 gms., the left 425 gms. Both showed slight edema and congestion. On microscopic examination the heart showed mild, widely scattered fibrosis and the muscle fibers were hypertrophied. There were absolutely no other lesions. The lungs revealed slight, moderate interstitial fibrosis with numerous macrophages. There was some pulmonary arteriosclerosis.

Case Three

AJ, C-F-45, (patient of Drs. W. G. Reid and G. B. Smith, not seen by the author) Gravida X, Para IX, arrived at the Medical Center on May 23,

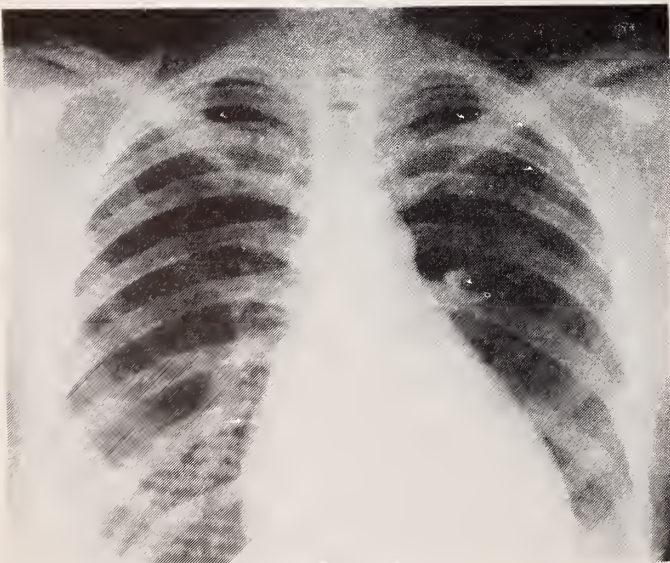


Figure 9: ABF, February 11, 1960.

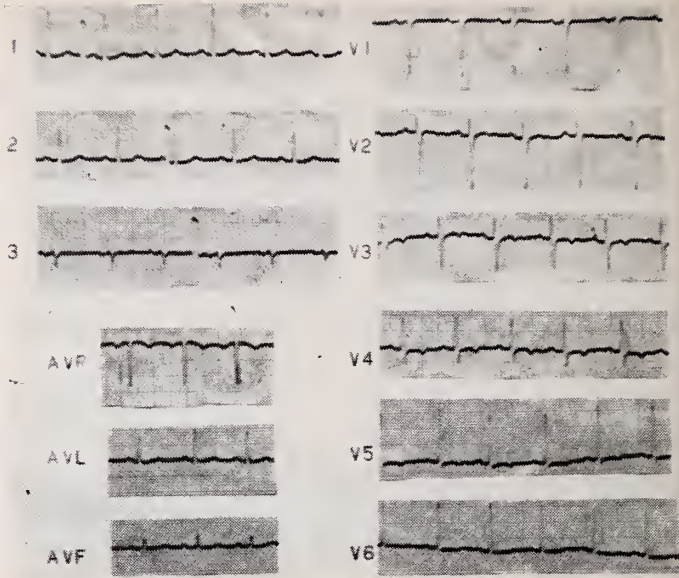


Figure 8: ABF, May 10, 1955. No essential change. T waves now upright in limb leads; there is less ST depression.

1959 in active labor; following an uneventful delivery, she was discharged on May 25. Except for the pregnancy, complete physical examination was normal. BP 120/80. The urinalysis and hemogram were normal except for a white blood count of 14,900. Four previous deliveries had been recorded in this hospital with the only abnormality being some mild anemia and “secondary bleeding.”

The patient was readmitted on July 17, 1959 because of a full-feeling in the chest, nausea, and vomiting. The BP was 100/80, a paradoxical pulse, cardiomegaly, gallop rhythm, and hepatomegaly were present. Following a presumptive diagnosis of pericarditis, paracentesis produced only heart blood. Except for a spike of 100° on the fourth hospital day, there was no fever. A three-plus albuminuria was present. The blood count, serology, sickle cell preparation, sed rate and ASO titer were normal. (See Figures 11 and 12 for EKG and x-ray.)

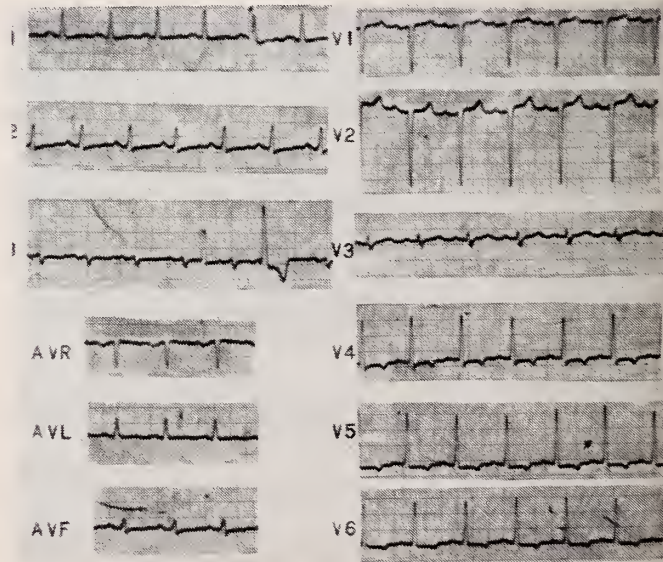


Figure 10: ABF, February 11, 1960. T wave changes V1-V3 have regressed.

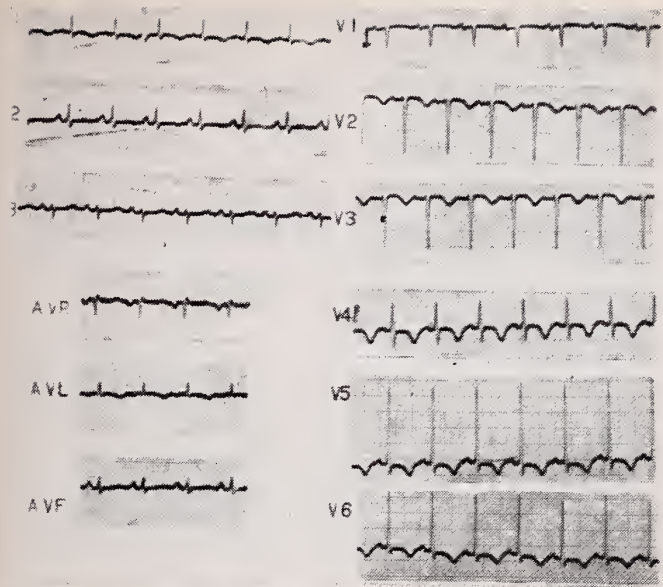


Figure 11: AJ, July 23, 1959. Low or inverted T waves. ST depression.



Figure 12: AJ, July 21, 1959.

After Improvement Patient Suddenly Died

After improvement the patient was discharged on August 6, only to return one week later because of dyspnea and diarrhea. The physical findings were essentially unchanged. Many laboratory studies revealed only urinary albumin. On August 16, a regime of therapy, including digitalization, hydrochlorothiazide, and sedation were instituted, but she expired suddenly on August 18. No autopsy was obtained. (We would like to express our thanks to the above physicians for permission to use this case).

Physicians Building

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OSCAR HILLIARD HEADS HOSPITAL ADVISORY COUNCIL

OSCAR S. HILLIARD, administrator of the John L. Hutcheson Memorial Tri-County Hospital, Fort Oglethorpe, Georgia, has been elected chairman of the Hospital Advisory Council for Construction, Licensure and Indigent Care of the Georgia Department of Public Health.

The Council is a consolidation of three separate committees established to advise the Department in these areas of operation.

Mr. Hilliard, past president of the Georgia Hospital Association and the Southeastern Hospital Conference, had served as chairman of the committees on construction and indigent care. He came to Fort Oglethorpe in 1952 from the Athens General Hospital where he had been administrator since 1949. Before coming to Athens, he was assistant to the director, University Hospital, Augusta.

Membership of the Advisory Council includes representatives from organizations interested in providing adequate hospital care throughout Georgia. They are as

follows: Medical Association of Georgia, Dr. W. L. Pomeroy, Waycross, Dr. Rafe Banks, Jr., Gainesville, and Dr. A. B. Conger, Columbus, who will serve as vice-chairman of the Council; Georgia Hospital Association, Daniel E. Gay, Savannah and Oscar Hilliard; Georgia Nursing Association, Mrs. Olive L. Barbin, Augusta; Georgia Dental Association, R. A. Rainer, Jr., McDonough; Georgia Association of Hospital Governing Boards, R. C. Cropper, Macon; Consumers of Hospital Services, John P. Duncan, president, Georgia Farm Bureau, Quitman, Edgar J. Forio, vice-president, Coca-Cola Company, Atlanta, and Noah Langdale, Jr., president, Georgia State College, Atlanta; Georgia Association of County Commissioners, James H. Aldredge, Fulton County Commissioners, Atlanta; and Ex-Officio members, Eugene Cook, State Attorney General, B. E. Thrasher, State Auditor, Alan Kemper, director, State Welfare Department, and A. P. Jarrell, director, State Vocational Rehabilitation.

TRAUMATIC HIND-QUARTER AMPUTATION

Battle surgery has as its peace time rival causative agent, the automobile.

John H. T. McPherson, Jr., M.D., *Athens*

WE HAVE ALL HAD occasion to be amazed at the extreme degrees of trauma which the human organism has at times been able to survive. Battle surgery has as its peace time rival causative agent, the automobile.

This is a case presentation of a traumatic hind-quarter amputation with survival. This 22-year-old white, male, college student was admitted via ambulance August 7, 1957, approximately one hour after an automobile accident. The patient was admitted in profound shock, bleeding from traumatic avulsion of the entire right lower extremity, including hip, buttock, and a portion of the pelvis. The peritoneum was completely denuded where it was exposed in this area, but was fortunately intact. The genitalia were intact, although a large wound of the scrotal wall on the right side was present. The perianal region was completely denuded of skin, but the anal sphincter was not disturbed. There were also extensive injuries to the left foot and heel, multiple fractures of the mandible and maxilla with the loss of several teeth, and multiple minor contusions, lacerations, and abrasions of face, trunk, and extremities.

Intensive treatment of shock was instituted immediately upon admission with administration of intravenous plasma expander followed by blood as soon as could be obtained. The patient was taken to the operating room where under general anesthesia completion of the traumatic avulsion of the right lower extremity was carried out. Hemostasis was achieved, a catheter was placed in the bladder, and massive dressings applied. Dressings and splints were applied to the left heel and lower leg. The

patient was then returned to his room, given blood transfusions, anti-tetanus, anti-gas serum after a negative skin test, tetanus toxoid, and massive doses of antibiotics.

On the third hospital day the patient was again taken to the operating room and general anesthesia administered. The dressing of the right side of the pelvis was removed and thorough debridement and irrigation carried out. A transverse colostomy was performed to divert the fecal stream from the perineal wound. The patient withstood this procedure reasonably well, and was returned to the ward in fair condition. He was seen by a dental surgeon in consultation, and treatment of the fractures of the mandible and maxilla, and the multiple broken teeth was begun.

Normal Alimentation Started

After the colostomy was open and functioning well, normal alimentation was started, and the general condition of the patient began to pick up rapidly. On September 7th he was taken to the operating room and split thickness grafts from the right lateral chest wall applied to the right hip region. The granulating wound of the left leg and heel was further debrided with removal of several bits of necrotic bone, soft tissue, and this wound was likewise covered with split thickness skin grafts. The patient was placed on a high protein, high vitamin, high caloric diet. Hemoglobin was maintained by oral iron, and when necessary by blood transfusions. The graft to the hip region and to the heel was approximately 80 per cent take. On October 31st a second skin graft, this time from the left thigh, was carried out completing the coverage of the right

Presented at the *106th Annual Session of the Medical Association of Georgia, May 3, 1960, Columbus, Georgia.

hip region and the heel. The patient withstood this procedure quite well. By December 1st all wounds were healed, and the colostomy was functioning well.

Ambulation with a walker was started under direction of a physical therapist. This brought about tremendous improvement in the morale and mental outlook of the patient, who had been apathetic and depressed during his entire hospital stay prior to this time. He made rapid improvement with the walker, and after two weeks graduated to crutches, which he learned to master with difficulty because of the instability afforded by his bandaged and tender left heel. However, he soon became able to walk up and down the hall and about the hospital with his crutches.

The multiple fractures of the mandible and maxilla healed well under the treatment of the oral surgeon. All teeth were finally extracted and plans made for fitting dentures.

Applied to Vocational Rehabilitation

Early in February application was made to Vocational Rehabilitation for financial aid in providing a prosthesis for the right lower extremity to enable the patient to walk so that he might return to college and complete his education. The patient remained in the hospital until March 22, 1958 at which time dental work had been completed. He was walking well with crutches, and sufficient encouragement had been obtained from officials to believe that he would be accepted on the Vocational Rehabilitation program, the prosthesis applied and training in the use of it provided through this agency. At the time of discharge the colostomy was still functioning, it having been decided that this method of handling bowel movements was preferable, at least until the new prosthesis could be obtained and the patient

taught to use it. The patient was discharged to his home in Griffin, Georgia.

Discharge Summary

1. Traumatic avulsion entire right lower extremity including hip, buttock, and a large portion of the right side of the pelvis.

2. Extensive avulsion and laceration of the left lower extremity, including partial avulsion of the Achilles tendon, os calcis and the soft tissues of the heel.

3. Multiple fractures of the maxilla, bilateral fractures of the mandible with multiple broken or lost teeth.

4. Multiple minor contusions, lacerations, and abrasions of the face trunk and extremities.

Supplement

As a supplementary note to this case report, it might be added that this young man was recently visited in his home—approximately two years following discharge from the hospital. At this time he had gained a considerable amount of weight, and presented the appearance of much greater vitality and vigor than at the time of discharge. He was walking easily with crutches. He had obtained a prosthesis, but had not yet mastered the use of it. He was driving a car and carrying on a fairly active social life. There were definite plans to re-enter college in a few weeks and complete approximately three months of college credits necessary for him to receive his degree in Business Administration. It was felt that after this young man has won his college degree and obtained suitable employment, he will have every chance of becoming a self sufficient, useful, and well adjusted member of society.

1010 Prince Avenue

PROSPECTIVE MEDICAL STUDENTS

THE FOLLOWING RESOLUTION, Resolution 41, introduced by the California delegation, was approved by the House of Delegates of the American Medical Association, Miami Beach, Fla., June 13-17, 1960:

Whereas, The uptrend in education, income and urbanization places a heavier burden on the doctors; and

Whereas, The rate at which doctors are trained needs to be stepped up; and

Whereas, The number of students who applied for admission to medical schools last Fall dropped to 1.8 times the freshmen capacity; and

Whereas, The aim of medical leaders should be to attract greater numbers of qualified students whose interest is now being diverted to engineering and its ancillary fields of nuclear science, electronics and missiles; and

Whereas, Engineering groups go directly to high schools and present in person all of the desirable assets of engineering to science students; and

Whereas, The American Medical Association has produced some excellent literature for use in attracting qualified medical students but this material has not been adequately used in many areas; therefore be it

Resolved, That the American Medical Association, through its component state medical associations, and the various county medical associations, present medicine's story to the high schools of the nation in person.

THE FIVE-DOLLAR INTERVIEW WITH THE OLDER NEUROTIC PATIENT

Leonard T. Maholick, M.D., *Columbus* and

John Warkentin, Ph.D., M.D., *Atlanta*

The general practitioner and internist, especially, represent key lines of defense against mental illness.

LADIES AND GENTLEMEN, I doubt if there is a single physician who can now rationally deny the ever-mounting presence of mental and emotional disorders. These statistical facts cannot be ignored even though, at times, all of us would like to wish them away. Furthermore, so long as our patients continue to have thoughts, feelings, and behave in certain ways, we cannot avoid the responsibility of dealing in a knowledgeable way with the person in the patient—whether the patient suffers from a “physical” and/or “emotional” disorder.

Even though psychiatry is here to stay and is winning a respected and responsible place in medicine, we would be the first to admit that psychiatrists cannot deal effectively with all the known needs for their services. Training additional large numbers of psychiatrists and other related professional personnel is not the answer either.

A telling blow on these vast and complex problems can be made only when a united medicine girds itself to do battle each and every instance these problems are seen. The general practitioner and internist, especially, represent key lines of defense against mental illness. The potential they and all other physicians possess has not yet been realized nor activated.

Sounds good you say, but *how can this be done?* To achieve the above will require your taking at least the following four steps: a look at yourself; a look at “common sense”; an effort to acquire new knowl-

edge, and the courage to apply new methods and techniques in your everyday practices.

A Look at Yourself

How can you hope to succeed in this venture if you have a skeptical, cynical attitude toward psychiatry and what it has to offer? If you are unable to revise your prejudices against psychiatry, how can you even recognize the symptoms of emotional disorders, much less do anything about them? Unknowingly, it is the patient who suffers the most.

Common Sense

Is it really good enough? Be honest with yourself. Are you quite certain you can always recognize anxiety when it is present in the patient? If you suspect it, do you know how to proceed to bring such feelings to the surface, even when the patient is trying to hide them from himself? Once exposed, do you know what to do—how to cope with it? Are you really technically prepared to treat the emotions of your patients? Do you know what you are doing or are you guessing essentially, relying on your personal experiences or your bedside manner? Or are you using just plain “common sense”? Don’t misunderstand me. This may be sufficient at times, but then you probably are not dealing with a very complex or difficult problem. The fact is, common sense by itself is no longer good enough. Actually, a great deal of “uncommon sense” is required in the form of new knowledge. No one would deny that our fund of knowledge has grown in all fields of medicine, and this includes psychiatry.

New Knowledge

All emotional illness is basically a result of abnormal handling of the conflict between personal needs and reality. Each person has a group of defense mechanisms (protective devices) which he uses to cope with these stresses. These patterns are usually limited in number, are characteristic of the

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individual, are used in all situations, and can be identified by the physician, if he looks closely enough as he attends his patients. Much can be learned about this by your reading and self-study, attending special courses, and/or by critically observing your patients—they are excellent teachers. Not a few of you already know this.

New Methods and Techniques

To begin with, you will have to review your concepts of time and money. There is no doubt about it, medical time is expensive, both to the doctor and to the patient. I once heard a physician say, "When I do something for a patient I cannot charge, I feel like an amateur and resent it, too." Helping the neurotic patient requires the use of your valuable time and you must charge for it. In dealing with emotional disorders, your basic therapeutic tool is the interview, which according to Otto Will, "may be looked upon as a miniature of all communication processes, containing within it the essential qualities of all human relationships, and much data relevant to the getting along of a person in any social setting." The late Dr. Jacob Finesinger stressed that the interview is a vignette illustrating the particular patterns of living which make trouble for the patient. The physician, in one form or another, from time immemorial, has always interviewed his patients. However, *to help neurotic patients it must be structured* in a different way. This can be done effectively, even though the average physician does not have the time to conduct the usual type of psychiatric consultation.

Examples

In Atlanta the story is told of one very difficult elderly lady who was dying of cancer. Despite her family's effort to keep a doctor on the case, the patient was so uncooperative that she ran off a whole series of excellent physicians, one after the other. Finally, she took a great liking to a new doctor, and the family was overjoyed that medical care would now be possible during her final weeks. However, after completing his examination, the physician refused to return because he could not save the patient's life and he saw no reason why the nurse could not give the shots rather than himself. The family pleaded with the doctor to continue on the case, even if he could not change the course of the disease. They asked if he would just talk with the old lady periodically, since he was the only one with whom she would cooperate. However, he adamantly refused, saying that he did not do this kind of work.

We are suggesting that this physician lacked the courage to apply new methods. He could have

rendered a valuable medical service to this elderly patient and her family, if he had regarded more highly his professional capacity in interviewing. If he had spent five or ten minutes a day with her, this could have offered genuine emotional support. It would have been a normal extension of the doctor-patient relationship, deserving the same respect as physical examination and physical treatment.

Certain problems do arise when we as physicians offer to "just talk" with patients. One general practitioner in a small Georgia city (we shall give him the fictitious name of Dr. Boswell) decided to spend more time talking with his patients. He was very much disturbed when one of them shortly afterwards committed suicide. He talked this over with a colleague, who encouraged him not to give up trying because of failure in one case. Dr. Boswell agreed and began by systematically setting aside the hours from 4:00 to 6:00 P.M. on Tuesdays specifically for patients scheduled for treatment by interview. Some patients at first misunderstood his effort and thought he wanted to become their social friend; they gave him dinner invitations, wanted to go out fishing with him, or otherwise denied his professional function. Other patients began to think of him as a substitute father whom they should not pay for just talking, since "nobody would pay a father just to talk with him." Still other patients began to telephone him at all hours of the day and night to ask his advice about many things, mostly non-medical problems of living, such as how to conduct their business.

Without special psychiatric instruction, Dr. Boswell gradually learned new techniques of interviewing neurotic, defensive patients. He found that it is important for the physician not to desert his medical role, and refused the dinner invitations. He emphasized the importance of the interview by avoiding interruptions by the nurse and telephone during his scheduled 10 to 15 minutes with each patient. He emphasized to patients that they should make specific appointments on Tuesday afternoons and keep them, even though he did not run the rest of his practice by appointment. This definite planning of the interview time added a new dignity to his interview therapy, and patients stopped telephoning him so much and brought their concerns to him at the appointed time. When the patients asked about coming to talk with him at his home, he offered them instead a definite time to talk with him at the office on Tuesday afternoons. When they tried to get a physical examination also at such times, he said that his interview time was special to him, and he would examine them or prescribe physical treatment during his regular office hours otherwise. In this way, the patients he saw for interview treatment

FIVE-DOLLAR INTERVIEW / Maholick

remained fully clothed, no nurse needed to be present in the room. The patients developed a comfort about talking with him which had been absent in the rest of his office practice, where he was constantly under pressure to push on to see the next patient. In the scheduled interviews, each patient knew just how much time he would have with the doctor.

Dr. Boswell's technique in interviewing underwent a change as he worked in this way on Tuesday afternoons. He gradually came to do less talking and more listening. He accepted the fact some patients would improve only very slowly over a period of months. He found that a major part of dealing with neurotics, especially elderly patients, was for the doctor to withdraw his initiative in the interview; the patient then came to exert more of his own initiative and motivation. In this way he was able to help elderly patients who had gradually withdrawn from social activities, so that they again made the effort of seeking human companionship. He encouraged them to talk about such things as their loss of physical attractiveness, their loss of energy, and their sense of being rejected when they were retired from work. In fact, he found that patients valued an opportunity to "cry on his shoulder," and that he did not have to make encouraging comments when they did so. When one patient, a retired businessman, said that he "had nothing to live for," Dr. Boswell suggested, "And at your age it may be difficult to find much to live for." This was a real challenge to the patient. He rather promptly set out to find new interests in life for himself and thanked Dr. Boswell for this new "lease on life."

One of the unexpected outcomes of doing treatment by interview was Dr. Boswell's discovery that just the doctor's "presence" for 10 or 15 uninterrupted minutes can have major value for a patient. Some patients became rather dependent on him, like a child crying with some pain or fear. He found that he did not need to do or say anything about this; just his understanding and awareness of their situation gave emotional support to patients and resulted in medical improvement. Actually, Dr. Boswell himself came to look forward to his Tuesday afternoon time for treatment interviews as one of the more rewarding functions of his medical practice.

Conclusion

Very brief interviews which are properly structured in keeping with known psychotherapeutic principles, and for which a reasonable fee should be charged, can be a most valuable adjunct in any doctor's office. This is especially true in dealing with patients dying of incurable illnesses, aging gradually and feeling this as an emotional threat to their adjustment,

as well as with those we all know as the older neurotic patient.

The Bradley Center

Comments

Dr. Clarence C. Butler, Columbus: I think Dr. Maholick and Dr. Warkentin have done a very excellent job in pointing out a problem that is becoming increasingly difficult for the G. P. and internist—the handling of the emotional problems and disorders, not only of the neurotic patient, but also the chronically ill individual.

Dr. Maholick refers to the "skeptical, cynical attitude toward psychiatry . . . and your prejudice against psychiatry." This was true for many years, but I do not believe it exists to any great extent now. We have long since accepted psychiatry as an integral part of medicine. Psychiatric principles, when properly applied, are a tremendous help in the management of certain medical problems, i.e., cardiovascular disease and especially in the rehabilitation of the stroke victim.

He states that to implement a program of proper management of the emotionally disturbed patient in our practice, we must take four steps: a look at ourselves; a look at common sense; an effort to acquire new knowledge; the courage to apply new methods. I will agree with the first three, but the last, why apply new methods before we learn to renew or expand old methods. I'm referring to the art of talking to the patient and being willing to listen.

In the process of taking a complete history, we use the age-old method of interviewing. This is when we arrive at an impression of the diagnosis. Certain technical aids are then used to substantiate this impression. Perhaps, we have allowed the technical aid to assume too much importance—particularly as applied to the emotionally disturbed patient.

Psychiatry brings attention back to just talking—not only as a diagnostic tool, but also as a therapeutic tool. This talking and discussion must have a definite structure and goal and not be aimless wandering. This, some of us must learn.

The element of time is a pitfall we must use and not let it use us, if we are to assume a first line of defense as is suggested. Certainly, many of us do not have the time for interviewing—time, that is, as the psychiatrist uses it. But it is important that we adjust our schedules so that more time can be allocated to these problems as they arise. If this is done, and a special setting is used—special in the sense that we use treatment rooms, x-ray rooms, etc., why not a talking room? Then, and only then, can we learn to use the tool to its fullest extent. Also, as mentioned by Dr. Warkentin, the patient accepts and appreciates this and is willing to pay for talking time.

THE DIAGNOSIS OF INTRACRANIAL NEOPLASMS BY MEANS OF CEREBRAL ARTERIOGRAPHY

Not only is it possible in a high percentage of cases to demonstrate cerebral tumefactions, but further by virtue of the fact that each tumor has its own characteristic vascular pattern, a more accurate pre-operative pathological diagnosis is possible.

Homer S. Swanson, M.D., *Atlanta*

FOSTER KENNEDY, THE eminent neurologist once said, "He who cares for patients suffering from the brain tumor must bring to his problem much thought and stout action. There is need, also, of a formidable optimism for the dice of the Gods are loaded."

There is perhaps no field of surgical endeavor in which there exists such a wide variation in the operative management of neoplasms as that which is presented in intracranial tumors. The surgical approach which may prove to be correct in one instance may be productive of a mortality or a prohibitive morbidity in another. It is an established fact that brain tumors cannot be collectively considered as a disease but that different histogenetic types of brain tumors each represent an individual disease which has only this in common with other varieties of brain tumors; they are all located inside the cranial cavity. It is just as important, therefore, to know the type of brain tumor one is dealing with for purposes of diagnosis, therapy, and prognosis as it is to know whether a patient presenting primary gastric symptoms is suffering from cancer, ulcer, benign adenoma, or perhaps the now rare syphilis of the stomach.

Within the past two score years, many diagnostic adjuncts have been developed which have furthered our diagnostic acumen with reference to intracranial tumors. Each method has certain distinct advantages but, unfortunately, none are all inclusive because of the inherent limitations of each procedure. Even after utilizing all available diagnostic methods, one frequently is faced with the necessity of biopsy in

order to establish the correct histological diagnosis for purposes of appropriate therapy.

Preoperative Pathological Diagnosis

The correct preoperative pathological diagnosis of intracranial tumors arising from the meninges, the cranial nerves, or other extracerebral structures is possible in approximately 35 per cent to 40 per cent of the cases by means of plain roentgenograms of the skull alone when combined with the clinical data. The following illustrations demonstrate radiological changes of pathognomonic types:

The presence of the hyperostosis seen in Figure 1 in the superior frontal region bespeaks the presence of an underlying benign meningioma or meningeal

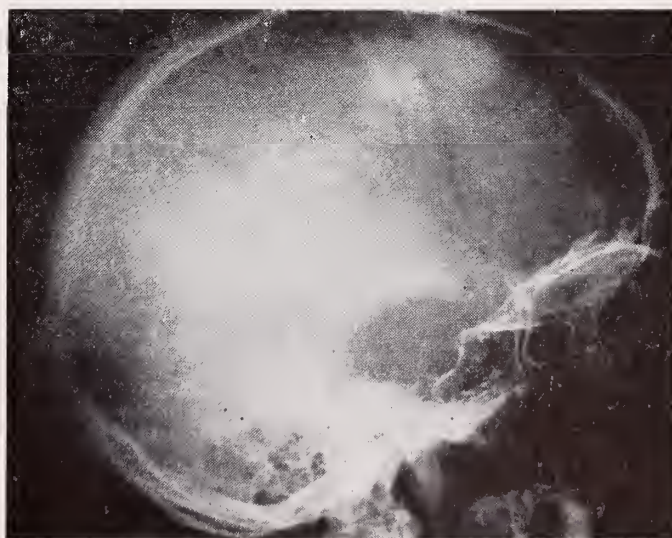


Figure 1: Typical enostosis of inner table of skull in superior frontal area characteristic of meningioma.

Presented at the Oklahoma University Postgraduate Meeting, October, 1957, Oklahoma City, Oklahoma.

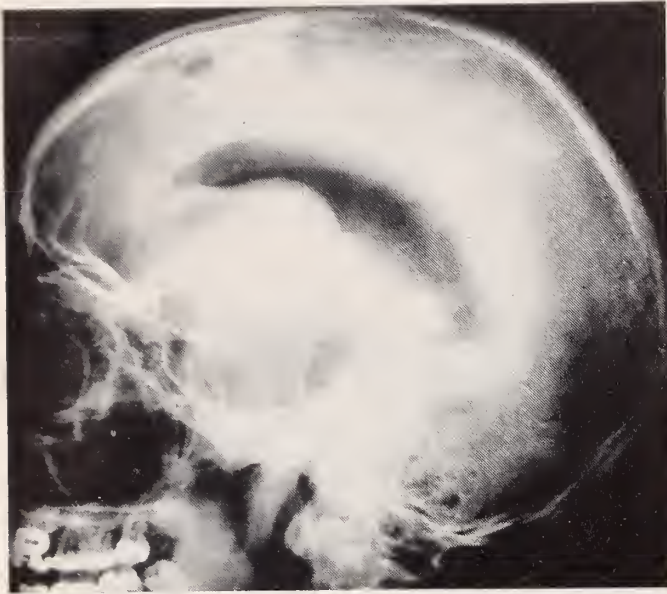


Figure 2: Marked intrasellar expansion noted in a chromophobe pituitary tumor which has, as the ventricular deformity shows, extruded superiorly from the sella.

fibroblastoma and the energetic surgical attack upon such a lesion is justifiable in anticipation of a cure. In a high percentage of cases exhibiting the sellar changes noted in Figure 2, the clinical diagnosis of pituitary adenoma will be proven to be correct. To illustrate the diagnostic difficulties facing the neurological surgeon, it should be pointed out that aneurysmal lesions of the internal carotid artery may produce identical sellar changes as will certain chronic suprasellar or parasellar lesions. Furthermore, in instances of chronic obstructive hydrocephalus, the floor of the dilated third ventricle may, over a period of time, produce erosion of the clinoids. In this latter instance, the posterior clinoids usually bear the brunt of the pressure which frequently gives one the lead to the correct radiological diagnosis.

Many intracranial neoplasms are associated with calcification visualized on the roentgenogram films and the calcification so demonstrated may be characteristic for certain histological types of new growths. The suprasellar calcification in Figure 3 is, in most instances, characteristic of that seen in the congenital craniopharyngiomas, but to add to the confusion, mention should be made of the fact that we have personally seen identical suprasellar calcification in one instance of a glioma of the optic chiasm, the management of which is quite at variance with that of a craniopharyngioma.

Naffziger¹ first called attention to the significance of pineal displacement as being indicative of a space occupying intracranial mass. Although the presence of lateral pineal displacement on well aligned AP or PA skull films is presumptive evidence of a space



Figure 3: Flaky, granular, suprasellar, and perisellar calcification characteristically seen in the congenital craniopharyngiomas.

occupying mass, it unfortunately gives one no clue as to the character of the mass. A similar dilemma faces the neurological surgeon after ventriculography or pneumoencephalography first described by Dandy² in 1920. This radiological procedure has been of invaluable assistance in the positive demonstration of a wide variety of intracranial lesions but it likewise has inherent limitations. The gross ventricular distortion noted in Figure 4 is indicative of a mass supratentorial lesion but here again the histogenic variety remains undisclosed. The author does not



Figure 4: Mass ventricular deformity and displacement secondary to a right fronto-temporal brain abscess.

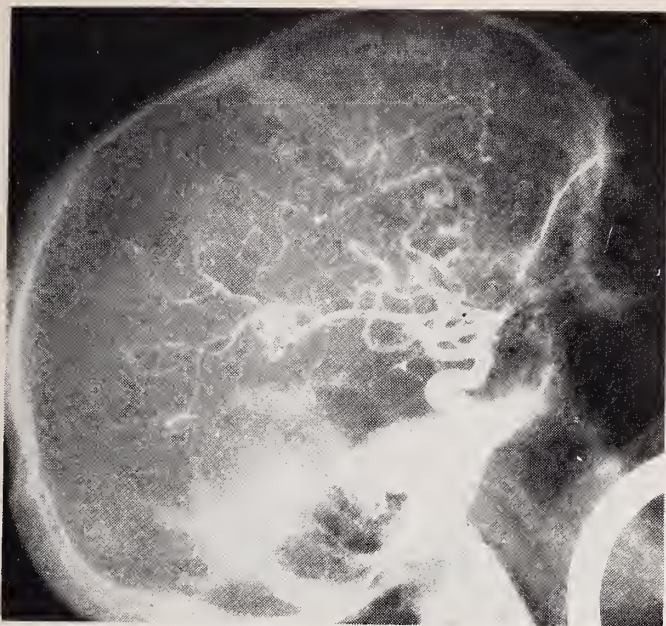


Figure 5: Lateral view of normal carotid arteriogram—arterial phase. The typical, normal, corkscrew appearance of the branches of the anterior and middle cerebral arteries is evident.



Figure 6: PA view of normal carotid arteriogram. Bifurcation of carotid artery into anterior (midline) artery and middle (lateral) cerebral artery.

wish to detract from the profound importance and the assistance gained by means of ventriculography, since this diagnostic procedure is, perhaps, as responsible as any other for the rapid advancement in cranial surgery. As with any diagnostic procedure, however, there exists limitations in its use as has been set forth with reference to confirmation of histological type.

The vicissitudes confronting the neurological surgeon in attempting to establish a more precise histological differentiation of cerebral neoplasms and allied surgical problems have been considerably lessened by means of cerebral angiography. This radiological procedure first developed by Moniz³ in 1936 has added much to our clinical knowledge of surgical cerebral pathology. Not only is it possible in a high percentage of cases to demonstrate cerebral tumefactions by this method, but further by virtue of the fact that each tumor has its own characteristic vascular pattern, a more accurate preoperative pathological diagnosis is possible. It is also possible only by this radiological adjunct to differentiate between intracranial new growths and vascular lesions, a fact which is of paramount importance in many previously undisclosed vascular malformations. For purposes of orientation, the next two illustrations (Figures 5 and 6) demonstrate a normal carotid arteriogram. In order to simplify this discussion, we shall refrain from a discussion of vertebral arteriography.

Perhaps the most significant contribution of the cerebral arteriogram in the diagnosis of intracranial pathology has been in first the differentiation between the malignant and the benign neoplasms and secondly, the differentiation between neoplasm and vascular malformation. The patient, whose arterio-

gram is seen in Figure 7, presented with a relatively short history. The clinical findings gave presumptive evidence of a space occupying mass in the left parasellar region. There existed considerable concern regarding the possibility of a malignant lesion, but the characteristic vascular pattern demonstrated here was compatible with the diagnosis of a benign meningioma. These benign, new growths are accompanied by a very abundant arterial supply and the numerous arterial feeders of the lesion are well outlined in this case. In contrast to the malignant intracerebral lesions, the meningiomas receive their major arterial supply from the middle meningeal artery.

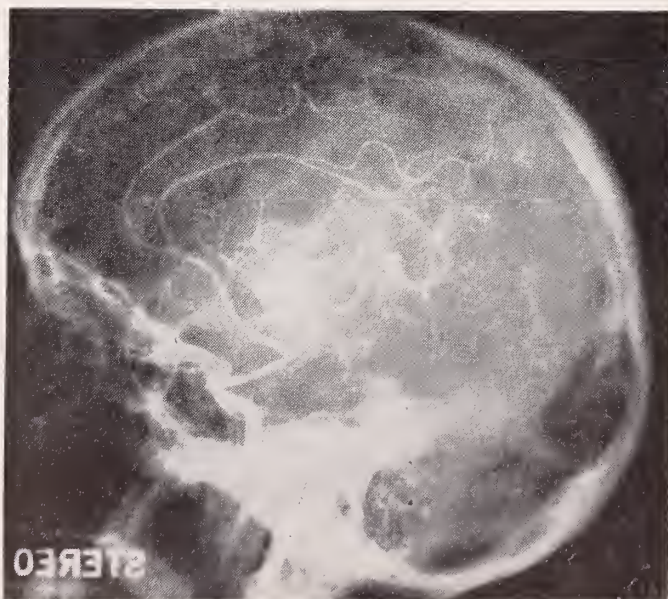


Figure 7: Gross backward displacement and bowing of middle cerebral artery together with marked new growth of arterial feeders from external carotid system (meningioma).

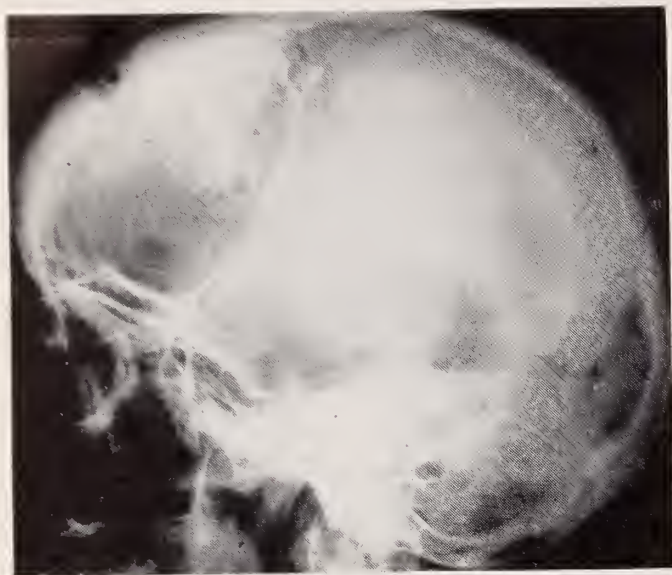


Figure 8: Venogram and Sinogram. Dye injected through midline burr hole into superior longitudinal sinus revealed blockage of sinus with reflux flow into entering Rolandic veins and inferior longitudinal sinus.

A variation of the arteriogram utilized in the surgical management of the benign meningiomas is illustrated in Figure 8. These tumors frequently arise from the dural reduplication in the midline referred to as the falx, and frequently invade the large draining superior longitudinal sinus enclosed between the layers of the falx. It is imperative that one have some knowledge as to the patency of this venous sinus, if one anticipates a total removal of the lesion and by means of venography or sinography as is here demonstrated, it is possible to ascertain whether the tumor has invaded the sinus in which case a ligation and excision of the portion of the falx containing the involved sinus may be accomplished with impunity.

Astrocytoma

One relatively benign glioma arising within the cerebral hemisphere is the astrocytoma. This tumor is frequently associated with a characteristic vascular pattern, as demonstrated in Figure 9, in which there occurs a straightening out of the corkscrew-like appearance of the major arterial trunks in the frontal area with a distinct paucity of arteriolar and capillary filling.

The viciously malignant glioblastoma and the metastatic cerebral lesions are, also, frequently demonstrable, angiographically speaking, by virtue of the fact that there occurs centrally in these lesions a so-called capillary blush with numerous small capillary buds seen in the next illustration. (Figure 10).

Although the author does not recommend the surgical attack upon metastatic cerebral lesions, there

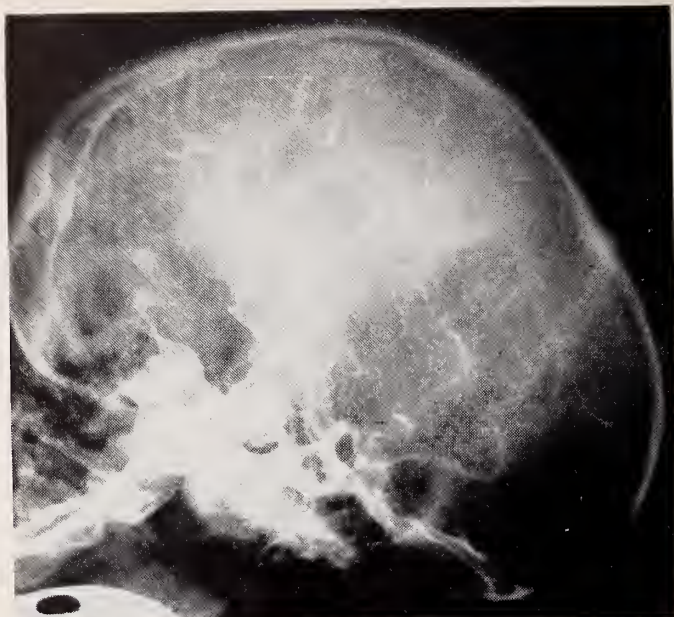


Figure 9: Note paucity of arteriolar filling and ablation of normal corkscrew appearance of arteries in frontal area as contrasted with normal vessels in parietal and occipital lobes (astrocytoma).

are rare instances in which metastatic cerebral lesions might justifiably be subjected to craniotomy. In certain selective cases, in which the primary lesion has been successfully dealt with and in which there occurs very shortly thereafter, evidences of a solitary cerebral metastasis, the removal of the metastatic lesion may be warranted, if one can preoperatively prove the existence of a single metastatic lesion. The illustration, Figure 11, demonstrates this infrequently encountered situation.

The patient in question had been subjected one year previously to a nephrectomy for the removal of a Wilms' tumor. His postoperative course was complicated on the fourth postoperative day by the

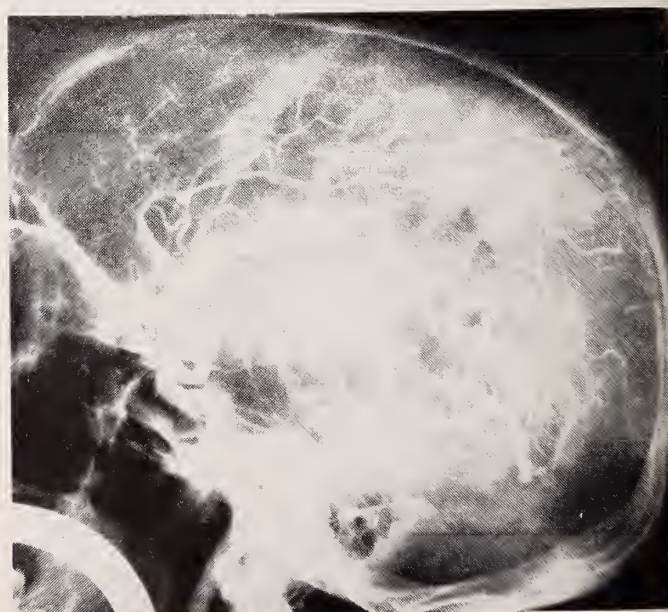


Figure 10: This demonstrates the marked degree of new blood vessel formation arising from intrinsic arteries which characterize malignant lesions (glioblastoma, right temporal lobe).

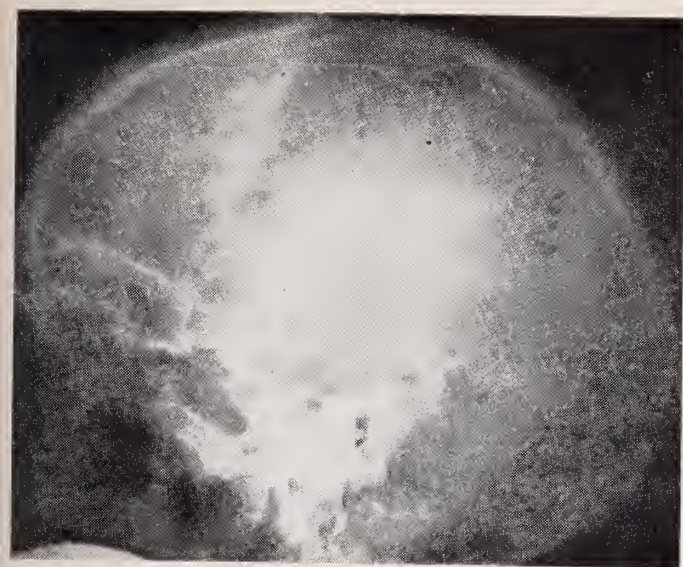


Figure 11: Marked concave elevation of middle cerebral artery with virtually no vessels noted in temporal area. (Right temporal lobe sarcoma, slow growing as evidenced by lack of new blood vessel formation).

appearance of previously unnoted left sided weakness, which shortly gave way to a left hemiparesis. The relatively abrupt onset of the hemiparesis, erroneously, suggested a cerebrovascular complication. This man was seen one year following the nephrectomy, presenting with intractable headaches, with marked signs of increased intracranial pressure of a chronic nature and with a severe left sided hemiplegia. The chronic signs of increased intracranial pressure were not in keeping with the previous diagnosis of a vascular complication and because of the long survival of the patient, following the nephrectomy and the need for measures to relieve suffering in an obviously chronic problem, studies were carried out to determine whether the suspected intracranial metastatic lesion might represent an isolated metastasis. As far as could be ascertained, there were no other systemic metastatic sites and a bilateral carotid arteriogram demonstrated a single mass lesion in the right temporal lobe which in the light of the vascular pattern here demonstrated, suggested a more favorable histogenetic type than is seen in metastatic adenocarcinoma. All factors having been carefully weighed, the lesion in the temporal lobe was exposed and was found to be an enormous solitary metastatic sarcoma, identical histologically with the original renal neoplasm. Unfortunately, the patient expired postoperatively due to damage to the posterior communicating and posterior cerebral arteries during the removal of this enormous lesion. A complete autopsy was carried out and the fact confirmed that a successful total removal of the renal lesion had been accomplished and there existed no other evidences of distant metastasis. Had the lesion been operated upon earlier before the tumor attained the mass size presented at the time of craniotomy, it is quite con-



Figure 12: Enormous aneurysm arising left internal carotid artery proximal to bifurcation.

ceivable that a more successful removal would have been possible and the patient's prognosis enhanced.

We have had two similar problems with more satisfactory end results. In one instance, it was possible to demonstrate the presence of a solitary metastatic squamous cell carcinoma, which made itself evident one month following primary pneumonectomy. The patient is still alive three years postoperative and remains neurologically intact. The other represents a similar situation in a five year survival following the removal of a metastatic cerebral scirrhous carcinoma, primary in the breast. Similar results with metastatic adenocarcinoma from either the thyroid, the breast or the lung have not been personally observed and this likely because of the tendency toward multiple metastasis with adenocarcinoma.

Pituitary Apoplexy

Hemorrhage occurring in pituitary adenomas, the so-called pituitary apoplexy, is a well documented occurrence. In such instances, the differential diagnosis between an acute subarachnoid hemorrhage, due to a ruptured aneurysm of the internal carotid artery and hemorrhage into a benign pituitary adenoma, may be difficult without the utilization of angiographic verification. One such patient presented with a very abrupt onset of symptoms: rapidly developing ocular palsies, acute subhyaloid

hemorrhages and papilledema, signs of rapidly developing increased intracranial pressure, and grossly bloody spinal fluid. There also existed marked visual field changes which were difficult to evaluate because of the level of unconsciousness of the patient. The past history revealed clinically suggestive evidences of a progressive dyspituitarism. The confusion which existed in differentiating between hemorrhage into a pituitary adenoma and a subarachnoid hemorrhage due to a ruptured aneurysm, was resolved by means of carotid arteriogram. The arteriogram demonstrated no evidence of vascular malformation but did demonstrate the gross distortion of the internal carotid artery both upward and backward, indicating a solid lesion, which proved to be due to a pituitary adenoma into which there had occurred hemorrhage. This patient survived, though with persisting neurological deficit.

Reverse Situation

The reverse situation is demonstrated in Figure 12. This enormous aneurysm of the internal carotid artery had compressed the optic chiasm and optic nerves in a manner similar to that seen in a pituitary adenoma. In addition, it had produced sellar changes which could be interpreted as those produced by pituitary adenoma. The demonstration, angiographically, of this large carotid aneurysm preoperatively made it possible to deal with the lesion correctly and safely without the operative catastrophe, which might have been anticipated, had this aneurysm not been suspected, and had an incision



Figure 13: Gross displacement to left of both middle and anterior cerebral arteries together with marked displacement of surface of cortex from inner table of skull (subdural hematoma).

been made into the capsule with the mistaken diagnosis of a pituitary adenoma.

One other clinical lesion, which frequently offers diagnostic difficulties, is the subacute or chronic subdural hematoma. In many such instance, the patient is either too confused or too stuporous to confirm or deny preceding head trauma, and the evidences of rapidly developing signs of increased intracranial pressure may be clinically in keeping with a malignant brain tumor. If one obtains an arteriographic outline, as is seen in Figure 13, in which the vessels are sharply displaced from the undersurface of the dura, a diagnosis of subacute subdural hematoma is substantiated preoperatively and the surgical results may be anticipated to be gratifying.

Approximately 40 per cent of the arteriovenous malformations may remain quiescent and asymptomatic until the abrupt development of either intracerebral or subarachnoid hemorrhage. With the development of the hemorrhagic diathesis, the diagnosis may then be established by arteriography. In a much higher percentage of such lesions, however, there may be a history of convulsions, associated with progressive neurological deficit, like that seen in infiltrating neoplasms of the cerebral hemisphere. If pneumoencephalography or ventriculography is carried out, there may be demonstrated only signs of cortical atrophy on the side of the lesion and the surgeon may, by this radiological method, be unable to demonstrate the cause of the patient's convulsions and progressive neurological deficit leading to the cortical atrophy. It is in such instances that cerebral arteriography is of tremendous assistance in differentiating between insidiously developing intracranial neoplasms and the progressive cerebral changes occurring in an arteriovenous malformation.

Arteriovenous Malformation

Figure 14 illustrates a very extensive arteriovenous malformation in a 52-year old white male, whose only clinical manifestation was that of two generalized convulsive seizures in a ten year period. In this instance, the calcification seen on the skull films gave correct preoperative leads as to the character of the pathology present and prompted the arteriography which correctly established the diagnosis. With the correct diagnosis and exact delineation of these lesions now possible by means of arteriography and with the newer surgical methods which have been developed to compete with the potentially fearsome hemorrhage which often occurs during the removal, it is now feasible to totally extirpate these once seemingly hopeless vascular malformations. Our personal experiences in dealing with these formidable intracranial lesions have been previously reported.⁴

In the foregoing discussion, we have attempted

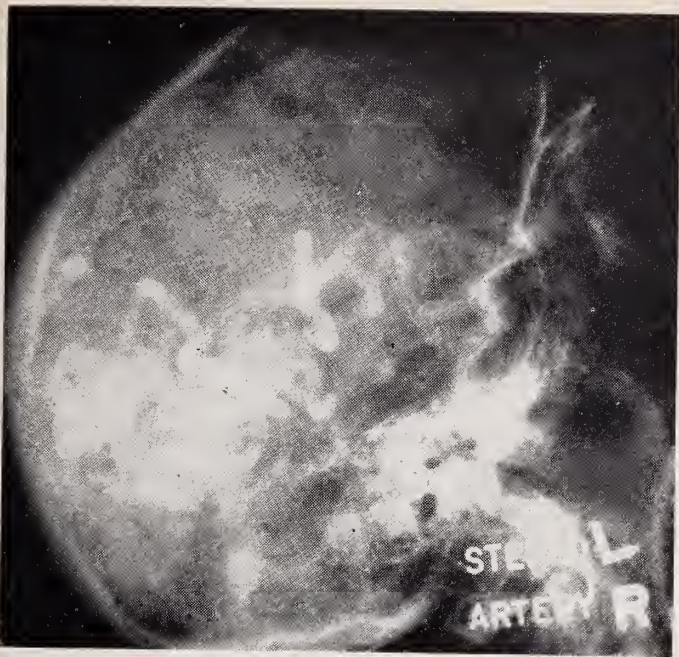


Figure 14: Huge occipital and parietal lobe arteriovenous aneurysm. Noted tremendous enlargement of feeding arterial branches.

briefly to set forth the diagnostic potentialities in the utilization of cerebral angiography. In addition to those set forth, there are other specific advantages which this procedure offers as opposed to pneumoencephalography and ventriculography. In patients presenting with evidences of massive increased intracranial pressure, there exists the real threat of the enhancement of the pressure phenomenon following the replacement of ventricular fluid with air, prompting the need for immediate surgical measures to compete with these factors. In such instances, the operative risk may be considerably increased and the surgeon is not afforded the opportunity to approach the problem as an elective procedure. In contrast to pneumoencephalography and ventriculography, angiography does not change existing intracranial pressure relationships, and, in addition to the histological diagnostic advantages gained by this method as opposed to ventriculography, there is distinctly less possibility of worsening the patient's condition. In addition, the surgeon has the opportunity to more leisurely and safely survey the problem as a whole prior to craniotomy. There is less need for movement of the patient for this procedure as opposed to ventriculography, and the postradiological sequelae following angiography is distinctly less distressing to the patient than that which follows ventriculography. It should be pointed out that as with any radiological procedure, unsatisfactory or poor cerebral angiographic films are probably worthless and it is unwise to attempt to interpret such films.

There are distinct limitations in this diagnostic method as well as inherent risks. There are many intracranial lesions, aside from neoplasms or space

occupying lesions, which cannot be diagnosed by this method. Furthermore, the procedure itself carries definite risk, especially in the older age group in which there may already exist evidences of primary vascular disease. The possibility of vascular damage with the development of neurological sequelae, due to complicating cerebral thrombosis or cerebrovascular spasm, is a real threat. The complications of arteriography with the use of any of the current contrast medias have been well documented and consist, for the most part, of the complications of intimal damage to patients with already existing atherosclerosis or in the younger individuals in whom a traumatic procedure has been accomplished. In our own personal experience, there have been no angiographic complications in individuals under 45 years of age with the use of our present radiopaque material, hipaque. Even in the face of existing atherosclerosis, the diagnostic advantages to be gained by this radiological procedure often far outweigh the operative risk.

Accuracy in Localization and Pathological Diagnosis

There are few statistical reports in the literature with reference to the accuracy in any large series of tumors in establishing either a correct localization of tumors preoperatively or in establishing a correct preoperative pathological diagnosis. Martin, et al,⁵ in a review of 200 proven tumors have reported a 57 per cent accuracy in establishing a correct localization of tumors by means of cerebral arteriography, but do not comment with reference to tumor type. In this same review, a much more accurate localization of tumors was obtained by means of ventriculography, an accuracy of 90 per cent. In 1952, Amador, et al,⁶ carried out a clinical experiment in which five separate investigators reviewed a series of 200 arteriograms on proven tumors. Each of the examiners reviewed the 200 sets of arteriogram films without previous clinical knowledge pertaining to the patients. The average accuracy with reference to correct localization of tumors was in the range of 73 per cent, whereas the overall accuracy in correctness with reference to tumor type was approximately 36 per cent. In our personal series of verified tumors subjected to angiography, a correct preoperative histological verification was obtained in approximately 60 per cent of the cases, all cases being hemispherical in location. It should be pointed out that the surgeon, who is cognizant of the clinical ramifications of the case, has a better opportunity to arrive at a correct histological diagnosis than an independant observer who has no knowledge of the clinical conditions but rather has available only the arteriographic films to review. These experiences certainly justify the feeling that in at least 50 per

cent of the cases, a reasonably accurate preoperative histopathological diagnosis may be established by means of cerebral arteriography. While the possibility of accurate localization of the tumor by means of arteriography is less accurate than by means of ventriculography, the added advantage of the possibility of preoperatively establishing a histopathological diagnosis gives added emphasis to this diagnostic procedure.

Familiarity Increases Ability

As one becomes more familiar with the interpretation of the cerebral arteriograms, there is noted a corresponding statistical increase in one's ability to correctly preoperatively establish the histological character of the lesion. In spite of the many advantages of this method, one is frequently faced with the need for the application of all diagnostic adjuncts available and even then there remains a disturbingly large percentage of cases in which biopsy of the lesion may be necessary for microscopic verification.

As Foster Kennedy has so aptly expressed it, "There is need for a formidable optimism for the dice of the Gods are loaded," in dealing with cerebral neoplasms. One soon learns, with added experi-

ence, that to gamble with the Gods is often times personally disastrous and ill-advised.

Conclusions

Cerebral arteriography offers another diagnostic adjunct in the clinical clarification of brain tumors. While ventriculography is the procedure of choice in the accurate localization of any intracranial mass, arteriography possesses the distinct advantage of a possible preoperative histological diagnosis. It is the only method available which makes possible a differential diagnosis between tumors and the various vascular lesions with which they may be confused. There are, however, distinct limitations as to its use, as has been set forth.

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SUGGESTIONS INVITED ON ATLANTA MENTAL HOSPITAL

SUGGESTIONS IN REGARD to the proposed 500-bed mental hospital to be built in the Atlanta area have been requested from leaders and members of several organizations interested in mental health.

Dr. John H. Venable, director of the Georgia Department of Public Health, has written to the head of each organization asking for written suggestions about the hospital and its program.

Any other qualified individual interested in the mental health program is also invited to submit suggestions, Dr. Venable explained. All suggestions, he said, will be given fair and serious consideration, and will be most helpful in long range planning.

Dr. Venable pointed out in his letter that within a very short time the architect for the Atlanta mental hospital will be selected. Details on the services to be offered at the hospital are being worked out by the Milledgeville State Hospital, the Health Department, and Emory University.

Plans for a four to six million dollar hospital in Atlanta were included in a "blue print" for mental health worked out by the Health Department and issued August 24 by Governor Ernest Vandiver. The hospital will be located convenient to Emory University, on the

grounds of the Georgian Clinic for Alcoholism on Briarcliff Road in Atlanta.

Dr. Venable's invitation was sent to the Georgia Association for Mental Health, Peyton S. Hawes, Elberton, chairman, and Frank A. Smith, Atlanta, executive director; the Atlanta Association for Mental Health, Philip H. Dohn, Jr., president, and Malcolm Lockhart, executive director; the Mental Health Committee of the Fulton County Medical Society, Dr. James N. Brawner, Smyrna, chairman, and Dr. Bernard Holland, Emory University, co-chairman; the Medical Association of Georgia, Dr. Milford B. Hatcher, Macon, president, and Milton D. Krueger, Atlanta, executive secretary; the Academy of General Practice, Dr. Ben K. Looper, Canton, president, and Dr. W. M. Moncrief, Atlanta, secretary; Interim Legislative Committee on Mental Health, Rep. Culver Kidd, Jr., Milledgeville, chairman, and Rep. Tom Palmer, Jr., Pelham, secretary; the Georgia Psychiatric Association, Dr. Rives Chalmers, Atlanta, president, and Dr. John Warkentin, Atlanta, secretary; the Georgia Psychological Association, Dr. Cecil H. Harbin, Decatur, president; and the North Georgia Chapter of the National Association of Social Workers, Carl S. Harm, Atlanta, chairman.

AMNIOTIC FLUID EMBOLISM

The uterus contained a term female fetus showing no gross abnormality and no evidence of placental separation or internal hemorrhage.

Laurence S. Bodziner, M.D., Savannah

THE PATIENT, Mrs. G. B., 31-year old white female, was a Gravida 5, Para 3, Abortus 1. Her first three pregnancies had terminated in perfectly normal spontaneous deliveries of full term healthy infants. The fourth pregnancy terminated in spontaneous abortion at eight weeks. This was followed by D and C for incomplete termination in May, 1956. A record of the patient's present pregnancy reveals that her last menstrual period had occurred on June 2 to June 6, 1958. This was also her last normal menstrual period. Her estimated date of confinement was March 9, 1959. On August 25, 1958 the patient presented herself at the office for pre-natal care and was found to have a 12 weeks gestation which was perfectly compatible with her history. From the patient's office pre-natal record, her weight at the time of her first visit during this pregnancy while some 12 weeks pregnant was 177 pounds. She was 5 feet 4 inches tall. Her blood pressure at the time of original visit was 140/80; her hemoglobin was 80 per cent. In view of the last pregnancy, having resulted in spontaneous abortion, the patient was placed on Hesper-C Prenatal,[®] one capsule three times a day. Blood work revealed that the patient was blood type O; Rh factor positive. The VDRL was negative. During the course of the patient's pre-natal care, which extended from August 25, 1958 until the time of admission to the hospital on March 15, 1959, her weight had gone from 177 pounds to 192½ pounds, a total weight gain of some 15½ pounds. Her blood pressure on her first pre-

natal visit, as stated previously, was 140/80, very slightly on an essential hypertensive side for her first examination. During the course of her pre-natal visits, her pressure at no time exceeded 140/80 and averaged in the range of 110 to 118/70 to 76. Repeated hemoglobins during the pre-natal time varied only from 70 to 80 per cent. The urine examinations were all negative, both for albumin and sugar. The only thing noteworthy in the course of this patient's pre-natal visits was that approximately two weeks prior to term, based on her estimated date of confinement, upon abdominal examination she was found to have a transverse lie presentation. Although considered abnormal, this late in pregnancy, I think most of us accept the fact that babies do change position up until the time the patient goes into labor and all of us have had the experience of the fetus actually changing position during labor. An attempt at external version in the office was done. However, it was noted that the polarity could not be changed with ease so no attempt to use force was made. It was hoped that spontaneous rectification of the polarity would occur with onset of labor and that the fetus would convert itself to either a vertex or breech presentation. One week prior to admission to the hospital on routine office visit and routine abdominal examination, the fetus was found to be in a vertex presentation. The fetal heart tones were 148 in the left lower quadrant. It was, therefore, felt that we were dealing with basically a perfectly normal, healthy young woman in her fifth pregnancy having had three normal children, one spontaneous abortion, and now having progressed to term with a

Presented at the *106th Annual Session of the Medical Association of Georgia, May 3, 1960, Columbus, Georgia.

normal weight gain and a completely normal picture. The last time the patient was seen in the office was March 9, 1959. The patient presented herself to the hospital in labor on Sunday evening, March 15th at 11:15 P. M., presumably in labor. Shortly prior to admission to the hospital the patient stated there had been a spontaneous rupture of the membranes. The patient had called me on the phone when this had occurred, and I had instructed her to report to the hospital immediately. This patient was seen by me about 30 minutes after admission to the hospital and was examined at that time. The history of spontaneous ruptured membranes was confirmed, and a note to that effect was made. It was also noted that the amniotic fluid had a greenish tinge. The fetal heart tones were found to be present, 140 in the left lower quadrant and regular. The fetus was in a vertex presentation and it was noticed that the vertex was high, estimated at a minus two station. The cervix was thick and long and would barely admit one finger. Re-evaluation of the bony pelvis clinically in view of the high presenting part with ruptured membranes confirmed the fact that the pelvis was adequate. During the night of admission to the hospital, the patient was in attendance by me and had irregular uterine contractions varying from five to 30 minutes and lasting from 10 to 30 seconds. The patient rested most of the night. The following morning, the 16th of March, the patient was again examined by me at 6:30 A. M. At this time, examination revealed that there had been no change in the cervix as far as effacement or dilatation and there had been no change in station of the presenting part since the patient had come to the hospital. She was given liquids only by mouth, since we felt that the onset of active labor was pending and simply a matter of a short period of time. The patient was again examined at 8:30 A. M. by my associate and his findings concurred with mine. This patient was, therefore, watched until 6:00 P. M. on Monday afternoon, March 16. At this time I again examined the patient, as she was having rather regular contractions about every eight minutes lasting about 30 seconds. The vertex was again confirmed as the presenting part and was found to be engaged in the pelvis at a zero station. The cervix was dilated to 2 cm. and beginning to efface. The fetal heart tones were again normal, 140 in the left lower quadrant. After consultation between my associate and myself, it was decided that this patient would be watched awhile longer. However, in view of the fact that the membranes had been ruptured for 24 hours, unless the patient began to have some progress promptly, a Pitocin® infusion to augment labor and antibiotics

were to be administered to this patient. At approximately 8:00 P. M. this Monday evening, it was felt that labor had been established as contractions were occurring every five minutes, lasting 45 to 60 seconds. The vertex was now firmly engaged and some 22 hours had elapsed since spontaneous rupture of the membranes. The patient had now become somewhat uncomfortable from the contractions and sedation was administered intravenously consisting of 25 mgms. of Sparine®, 25 mgms. of Demerol®, and 1/150th of hyoscine. This was at 8:00 P. M. For the next 30 to 45 minutes the contractions became somewhat less intense and somewhat less regular, so at 9:15 P. M., a Pitocin® drip consisting of 500 cc. of five per cent glucose in distilled water with one half ampule of Pitocin® was started slowly. A Pitocin® drip was administered at approximately 12 to 15 drops per minute. At 9:45 P. M., after some 30 minutes of the Pitocin® infusion, the patient had progressed to 4 cm. She was then quite comfortable so sedation was repeated in the form of 25 mgm. of Sparine® and 25 mgms. of Demerol® intravenously. At 10:20 P. M. the patient was examined by the nurse in attendance in the labor room and found to be 5 cm. I was informed that the labor was progressing very well and that the patient was being moved to the delivery room from the labor room. Upon receiving this call, I immediately responded and headed to the hospital. Approximately five minutes later I arrived in the delivery room and in this interval of five minutes while the patient was being transferred from the labor room in the labor bed into the delivery room and prior to transferring the patient from the labor bed to the delivery table, the patient had what was described by the nurse in attendance as a tetanic generalized convulsion. Upon further questioning, however, it was not a generalized convulsion. The nurse had noted that the patient's skin had developed a goose-pimple appearance. The patient had then suddenly become cyanotic and this cyanosis was noted over the lower part of the abdomen from the umbilicus to the pubis. There had been some twitching of the upper and lower extremities and patient appeared to then develop a deep obstructed type of respiration. Upon my arrival, which was about three minutes following this so-called convulsive type of attack, I found the patient in the labor bed in the delivery room and she was obviously in great distress. She appeared markedly cyanotic, extremely tense, and hyperactive. Respirations were extremely stertorous. Using a tongue depressor and with a fair amount of exertion on my part I was able to separate the teeth and insert an airway into the patient's mouth and throat. A call was immediately put in for the anesthetist, since this patient appeared critically

ill and it was felt that artificial respiration would have to be administered very promptly. After insertion of the airway, the throat and nares were cleared with a suction and it was noted that a bloody fluid was obtained from both the nose and from the mouth and throat. Oxygen was started in the oral airway. The first impression upon seeing this patient was that she had suffered a cerebral vascular accident. Needless to say, when one is confronted with a situation of this type everyone is moving extremely fast and furiously trying to do about six things at one time. The patient's blood pressure at this time was 96/60 and was dropping. It was promptly within a matter of a few minutes down in the low 90's and the high 80's. The Pitocin® infusion had previously been discontinued by the nurse at the time the patient had had the convulsive-like seizure. The abdomen was felt and the uterus found to be extremely rigid. There was no evidence of external hemorrhage. Fetal heart tones could not be heard. At the same time blood was drawn for a type and cross-match and Dextran® started with a recipient set and an 18 gauge needle. I requested an obstetrical consultation from my associate and also a medical consultation from one of the local internists. One of the local anesthetists arrived shortly thereafter and continued the administration of oxygen through the airway. A fibrinogen determination as well as type and cross-match was ordered on the blood, however, the fibrinogen was not available. It was noted, however, while waiting for the arrival of the technician that the blood did not clot in the test tube. As previously mentioned, upon aspiration of the nares and mouth at the time of inserting the airway, a bloody fluid was also obtained. At this stage of the situation I was not convinced that this was a CVA, since the patient was rapidly going into

shock and had a very tetanic uterus with no fetal heart tones, in spite of lack of evidence of external bleeding. One began to think in terms of obstetrical complications, such as abruptio placentae or a ruptured uterus. The patient was given rapid digitalization with Cedilanid® intravenously by the internist and also 100 mgms. of Solu-Cortef® was added to the infusion. At this point the patient emesed a large amount of yellow fluid from the mouth and at the same time approximately 100 cc. of bloody fluid was expelled from the vagina. The patient was also given calcium gluconate, 10 cc., I.V., and Neo-Synephrine®, ¼ cc., I. M. A tracheotomy was performed and oxygen continued through the tracheotomy. A call from the laboratory revealed that the blood in the tube which was drawn for the type and cross-match had still not clotted. The patient's pulse had become more rapid and her color had become more cyanotic. One unit of fibrinogen was started. At 12:15 A.M., now about two hours since the original attack, the patient was given 50 mgms. of Mephyton® intravenously. At 12:20 A.M., some five minutes later, respiration had ceased and there was no heart beat. The patient was pronounced dead at 12:20 A.M. The opinion of those present was that this patient had died of an amniotic fluid embolus with associated afibrinogenemia and possibly abruptio placentae. Permission for autopsy was obtained and autopsy performed. The pathologist's diagnosis was that of term pregnancy, amniotic fluid embolism, and pulmonary congestion. The small pulmonary vessels contained much epithelial debris. It is interesting to note that the uterus contained a term female fetus showing no gross abnormality and no evidence of placental separation or internal hemorrhage found to be present.

19 Medical Arts Center

HOSPITAL DIET INSTITUTES SET

FREE ONE-DAY INSTITUTES on modified diets will be conducted in five Georgia cities for hospital and nursing home food service personnel in October and November.

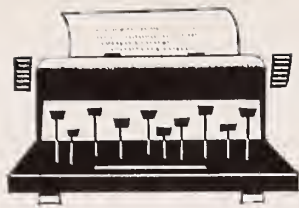
The institutes are sponsored by the Georgia Hospital Association and the Georgia Department of Public Health. To enroll, write Miss Helen Hovis, dietary consultant, Hospital Service, Georgia Department of Public Health, Atlanta, or register at the meetings. Meeting hours for all the institutes are 9:30 A.M. to 4:00 P.M.

A special feature will be discussion of a new 130-page Georgia Hospital Diet Manual published by the Health Department. The manual was compiled by the Medical Association of Georgia, the Georgia Dietetic

Association, and the Health Department.

Each institute program includes "New Trends in Modified Diets," by Miss Mary Nell Traylor, dietary consultant, Nutrition Section, Georgia Department of Public Health, and Miss Sarah Stulb, nutritionist for a U. S. Public Health Service heart study at Claxton, Georgia; "Use of the New Georgia Hospital Diet Manual," by Miss Hovis; and a demonstration of new food ideas by Miss Evelyn Kennedy, field dietitian, Southern Region, General Foods.

Meetings will be held at Americus-Sumter County Hospital, Americus, October 25; Macon Hospital, October 27; Athens General Hospital, November 9, and Battey State Hospital, Rome, November 11.



editorials

Your Vote is Essential

WITH THE NATIONAL elections only two weeks away, the campaigns of our two parties are moving at a rapid pace. Many of us by this time have probably decided how we shall cast our vote on November 8th. There are undoubtedly some, however, who prefer to defer their ultimate choice until the final day of the campaign in order to better evaluate the issues at stake.

Never in history have the people across the country had such an unparalleled opportunity to observe the candidates and hear the platforms of their respective parties at such close range. Both parties have availed themselves of every means of modern communication and transportation to bring the candidates and the issues to the people. Few citizens, regardless of status or geographic isolation will fail to have ample opportunity to assess the issues and observe the candidates closely. This is a unique opportunity when one considers the length and breadth of our land.

It is assumed that we as members of a learned

profession will have evaluated carefully all of the issues and the candidates by the time November 8th is upon us. It is expected that we will have considered first and foremost the future of our country in this year of crisis. It is expected that we will have considered the future of our children and their offspring, their opportunities for freedom and development in a favorable environment. It is expected that we will have considered the ways in which the medical profession may more effectively minister to the true medical needs of our people.

It is now nationally recognized that doctors have jeopardized their own position and the future of medicine by failing to execute their political obligations. The time is at hand to correct our past complacency.

These are some of the obligations to be met by informed citizens in a year of decision for all of us. Let us not default in our gravest responsibility in a democracy. *Go to the polls on November 8th and encourage others to do the same!*

Election Day Poster For Your Office

AN ATTRACTIVE POSTER for office display prior to and on election day, November 8, is being mailed with this issue of the *Journal*.

MAG is providing this placard in order to emphasize the importance of M. D. participation in civic affairs. The poster will also make it possible

for the doctor's employees and patients to go to the polls and vote during the designated hours.

Please use this poster and encourage your colleagues to use it. We feel it will help to remind your patients and the public that physicians are citizens first, too.

The Doctor and His Image

COMMENTS WERE CRITICAL with few words of praise.

The subject under discussion was the doctor of medicine as the public sees him. Perhaps an explanation of this hypercritical attitude can be attributed to the fact that it was self-analysis—participated in by physicians themselves.

This was the 1960 American Medical Association Public Relations Institute. Some 300 doctors, representing county medical societies and state medical associations, gathered for a two-day program concerned with public attitudes toward the medical profession.

Emphasis in depth was placed on the “doctor-patient relationship” as the genesis of good public relations. It was agreed, time and again, that the physician’s contact with his individual patient during diagnosis and treatment, was the very foundation of favorable public attitudes toward doctors. This conclusion, of course, underlines the impor-

tance of the “Art of the Practice of Medicine.” While it was said in many ways, it was made very clear that the art of medicine is a companion responsibility to the science of medicine.

If physicians, during their office visits, hospital visits, and house calls, would “personalize” their scientific treatment—if physicians would take time to treat from their heart as well as their mind—then their public image would, in reality, match their skill. The preservation of the doctor-patient relationship depends on these factors. It was further emphasized that “third party medicine” would only succeed when the physician abdicated his responsibility of maintaining real rapport with his patient.

In conclusion, the Institute presented a challenge to each doctor to improve his image to his own patients. Perhaps trite, but as true now as in the day of the Great Healer, is the fulfillment of His teachings of love and understanding for your patients.

Spider Bites

SPIDERS BELONG TO the class Arachnida, which also includes scorpions, mites, and ticks. Spiders can generally be recognized by their two distinct body divisions, the cephalothorax, which bears the mouth, appendages, and the long hairy legs, and the soft, round, unsegmented abdomen.

As a rule, most spiders are harmless. Their bite may produce a stinging or burning sensation with some local erythema or swelling, but without serious consequences. However, the venom of the brown spider, *Loxosceles reclusus*, may cause a necrotizing slough at the bite site a week or so after the bite.

Against the rule is the bite of the black widow, *Lactrodectus mactans*. Only the female *Lactrodectus mactans* is dangerous. It is said the black widow is so named because she devours her mate, although this is disputed by some authorities.

The black widow is easily identified by its shiny black chitin and the orange-red hour glass shaped spot on her under-surface. At times there may be several other orange-red spots caudad to the hour glass spot.

The black widow is found from Canada to South

America, and is widely distributed over Georgia and the Southeastern states. The black widow prefers an outdoor, dark, protected habitat, and is most frequently found under rocks, under lumber piles, under privy seats, in caves, and barns. When disturbed, the black widow will, in defense, inject its venom into the molester.

The venom is a thick, translucent, oily, yellow fluid believed to be a toxalbumin from which a hemolysin and a neurotoxin have been isolated. It has been noted experimentally that animals develop immunity to the venom and this probably also is true in man, although there is a case in the literature where a patient received two bites within 41 days and had symptoms following both bites.

The clinical symptoms following a black widow spider bite have been described by Blair, who in the tradition of John Hunter, allowed himself to be bitten on the hand. He was able to establish three stages of the clinical course. The bite is described as feeling like a pinprick. Following this, the first stage, which lasts about 20 minutes, is that of lymphatic absorption of the toxin. This is manifested by pain along

local lymphatics and tenderness in local lymph nodes. The second stage, lasting about four hours, is that of vascular dissemination. This is noted when the toxin reaches the systemic circulation and is characterized by diffuse, severe, agonizing muscle cramps, which increase in intensity for about four hours. Shock may also occur during this stage. The third stage, elimination of the toxin, is characterized by gradually decreasing muscle pains, sweating, headache, mild fever, leukocytosis, hypertension, and mild albuminuria. Blair also had facial and ankle edema and several days passed before he felt well again.

In practically all cases, the chief complaint is abdominal pain, which is severe and must be differentiated from that caused by some intra-abdominal catastrophe. On examination there is board-like abdominal rigidity. However, peristalsis is quite active. There is neither localized nor rebound tenderness, and the abdomen moves with respiration. Finally, these patients, in contrast to those whose illness is of a surgical nature, obtain relief from motion and are generally unable to lie quietly. The cramps, while most strikingly noted in the abdominal musculature, are also present in most other muscle groups, particularly those closest to the bite.

In the four cases which I have observed, all have had both periorbital and pedal edema appear during the first 12 hours following the bite, and all have had painful paresthesias of the lower extremities the next day. These symptoms disappeared within 48 hours. Of interest, three of these four patients were

bitten about the genitalia while using a privy.

Although deaths resulting from black widow spider bites are rare, the highest incidence ever reported being five per cent, the severe muscle cramps and the prolonged convalescence in untreated cases, make early specific treatment advisable.

When the patient is first seen, 10 cc. of 10 per cent calcium gluconate is given intravenously. This supposedly "protects" nerve endings and usually within five minutes relief of pain will be noted. This dosage may be repeated.

After the injection of calcium gluconate has been completed, the patient is tested intradermally for sensitivity to horse serum. If the skin test is negative, then 2.5 cc. of antivenom (Lyovac-Lactrodecus Mactans) is given intramuscularly. If, however, the skin test is positive, desensitization is not attempted unless other therapy has failed and the antivenom is believed necessary to save the patient's life. The dosage for lyovac is 2.5 cc., regardless of the patient's age or size. If symptoms persist, this dosage may be repeated in four to six hours.

Steroids are especially useful in the patient whose skin test to antivenom is positive; in the patient who has not been relieved by either calcium or antivenom, or in the patient who is extremely ill with shock, etc., Solu-Cortef,[®] 100 mgm., may be given intravenously and then oral dosages of prednisone, 5-10 mgm. q.i.d., for several days are used.

Fortunately, death from black widow spider bites is rare, and with early specific therapy, morbidity is also low.

W. E. Barron, M.D.

Department of Medicine

Medical College of Georgia, Augusta

Mills Bill Approved

THE ADVOCATES OF socialized medicine struck again in the recently adjourned Congress in the form of Forand type of legislation for the aged. This bill proposed to add 15 million more to the Social Security rolls. This includes those persons who have reached the age of 65 years. The supporters of this bill claim that only the federal government can cope with this problem. A study of the needs of the aged shows that everyone reaching the age of 65 are not in need of medical help and do not fall into that group of "hardship cases." It is an established fact

that the liquid assets of persons over 65 years of age have grown faster than any age group in the last ten years.

The Forand type of legislation had the backing of the labor group and many outstanding politicians. This type of legislation was drawn up under the Social Security system, with payroll deductions from the workers. This bill would not reach the needy or near-needy, but covered those drawing Social Security. It would freeze out millions of our citizens who really need help, but would bring in millions of

others who are able and willing to finance their own medical care. Remember this is a compulsory form of legislation. This bill was fought, with much energy, by the American Medical Association with the help of allied groups inside and outside the medical field. It was defeated on the last day of the short-political-session of Congress.

A substitute bill, The Mills Bill—title VI HR 12580—advocated by Representative Wilbur Mills, Chairman of the House Ways and Means Committee, and supported by the American Medical Association, was passed by the House and sent to the Senate. After a few minor amendments the Senate O.K.'d the bill and sent it to the President for his signature. This bill is designed to aid those who really need help. Those who are covered by voluntary prepaid health insurance can continue this coverage. This is not compulsory. The Mills Bill makes the state primarily responsible for administra-

tion of the program. It is a federal-state cost sharing project with the federal government carrying the greater load. It is a program which will help the aged citizens who need help and at the same time a program which the doctors can live with. This is not the end of the fight. The leaders of organized labor have added it to their must legislation along with cash benefits for workers who are ill; larger old age pensions through Social Security. The present victory will give the medical profession a short breathing spell. We must go out into the political field and help those whom we can count on to help keep medicine free from the control of the federal government. We must group our forces, add strength to our cause, and continue our fight for medical freedom, so that we can keep the best medical care in the world here in America!

Eustace A. Allen, M.D.

RESEARCH IN HEART AND BLOOD VESSEL DISEASES

RESEARCH WHICH SEEKS to determine the exact causes of heart and blood vessel diseases will reach its greatest peak in Georgia during the 1960-61 fiscal year, announced the president of the Georgia Heart Association.

Dr. A. Calhoun Witham of Augusta, former head of the publicly supported association, said that the organization has allocated a record \$171,000 for research, bringing to \$862,459 the amount the GHA has provided for heart research since 1950.

"The fact that the heart association can provide so much money for this vital cause indicates the tremendous interest the people of Georgia have in this voluntary health agency which has one primary purpose: the reduction of deaths and disabilities attributed to heart and circulatory disorders," Dr. Witham said.

The Augusta, cardiologist, in announcing 15 heart association research grants for 1960-61, said that such grants in this state alone total \$508,821 for the last 10 years, in addition to \$353,638 the GHA has sent to the American Heart Association for the nationwide research program.

"American Heart also selects outstanding Georgia scientists for research programs, thus some of our funds sent to the national association also return to us in the form of research grants," Dr. Witham said, adding that AHA has approved two projects for Georgians during the current year.

Speaking of the 15 Georgia Heart Association re-

search projects approved for 1960-61, Dr. Witham said that seven are for new investigations, while eight are renewals of grants previously awarded.

Dr. Witham said the new grants will support research on coronary arteriography, coronary perfusion, blood volume changes following open heart surgery, effects of cardiopulmonary by-pass and hypothermia, aortic regurgitation, aortic valve prosthesis, cardiac shunts, and atherosclerosis.

The 15 grants include renewed support for the Chairs of Cardiovascular Research at Emory University and the Medical College of Georgia at Augusta, held by Dr. Elbert P. Tuttle and Dr. J. Edwin Wood, respectively; the Established Investigatorships at both schools headed by Dr. Lois Ellison at the Medical College and by Dr. Robert C. Schlant at Emory; one Research Fellowship held by Dr. Nancy Thornton of the Medical College, and 10 grants-in-aid under the following:

Dr. F. Kathryn Edwards, Dr. Wade H. Shuford, Dr. Robert H. Franch, and Dr. Schlant, all of Emory; Dr. Edwin L. Brackney, Dr. Robert G. Ellison, and Dr. William S. Harms, all of the Medical College; Dr. William D. Logan, Jr., Georgia Baptist Hospital, Atlanta; Dr. J. Gordon Barrow, Heart Disease Control Division, Georgia Department of Public Health, Atlanta, and Dr. James B. Minor, St. Joseph's Infirmary, Atlanta.

In addition, Dr. Schlant and Dr. J. H. U. Brown, also of Emory, will direct the two newly-approved American Association projects in Georgia.

1961 Annual Session

May 7-10, 1961—Atlanta Biltmore Hotel, Atlanta, Ga.



Final Call for Scientific Papers

All titles must be submitted to the
respective program chairmen listed
below before November 1, 1960.

ANESTHESIOLOGY

John E. Steinhaus, M.D.
69 Butler Street, S.E., Atlanta 3
Jackson 3-4711

CHEST

Joseph S. Cruise, M.D.
348 Peachtree Street, N.E., Atlanta 8
Jackson 3-7726

DERMATOLOGY

William L. Dobes, M.D.
478 Peachtree Street, N.E., Atlanta 8
Jackson 1-2428

DIABETES

Ralph A. Murphy, Jr., M.D.
478 Peachtree Street, N.E., Atlanta 8
Jackson 3-2556

GENERAL PRACTICE

Clifton G. Kemper, M.D.
478 Peachtree Street, N.E., Atlanta 8
Jackson 2-9671

MEDICINE

Joseph H. Hilsman, M.D.
1211 West Peachtree Street, N.E., Atlanta 9
TRinity 5-6407

OBSTETRICS AND GYNECOLOGY

George A. Williams, M.D.
710 Peachtree Street, N.E., Atlanta 8
TRinity 3-3311

OPHTHALMOLOGY AND OTOLARYNGOLOGY

James T. King, M.D.
340 Boulevard, N.E., Atlanta 12
Jackson 3-8667

ORTHOPEDICS

J. Hiram Kite, M.D.
490 Peachtree Street, N.E., Atlanta 8
Jackson 2-7303

PATHOLOGY

Hugh V. Bell, Jr., M.D.
300 Boulevard, N.E., Atlanta 12
Jackson 5-7861 Ext. 331

PEDIATRICS

Joseph H. Patterson, M.D.
1405 Clifton Road, N.E., Atlanta 22
DRake 3-4401

PSYCHIATRY

John Warkentin, M.D.
2905 Peachtree Road, N.E., Atlanta 5
CEdar 3-9401

RADIOLOGY

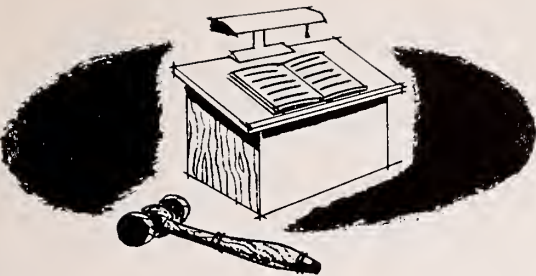
Ted F. Leigh, M.D.
Emory University Hospital, Atlanta 22
DRake 3-1621

SURGERY

A. Jack Crumbley, Jr., M.D.
683 Lee Street, S.W., Atlanta 10
Plaza 5-6684

UROLOGY

Thomas J. Florence, M.D.
340 Boulevard, N.E., Atlanta 12
JACKson 4-5082



president's letter

CITIZEN OR SLAVE?

ACCORDING TO HISTORIAN Channing Pollack, most democracies last for approximately 200 years. They are conceived and developed by vigorous, idealistic, and hard-working people. Eventually, they are replaced by other generations whose success brings wealth, comfort, and finally laziness, immorality, and tyranny. The cycle has been described as from bondage to spiritual faith, to courage, to freedom, to abundance, then to selfishness, to apathy, to dependency; after dependency back to bondage. Is America today wavering between abundance, selfishness, and apathy? If so, we must change this course of events by our efforts where it will remain with courage, freedom, and abundance.

All too often doctors let election day pass without exercising their right and privilege of voting, thereby also neglecting their duty. Medicine has for years attempted to remain aloof from politics—unfortunately, politics has not chosen to remain aloof from medicine. We should now take more interest in our government and our country.

The medical profession, along with other institutions—indeed, our very American way of life, the democratic system—is under the glare of world scrutiny and is being challenged. History points out that every civilization has decayed, not from outside forces, but from internal decay.

Each physician in the State of Georgia is being asked to study the issues and the candidates carefully and then to exercise his right by voting for the candidate who in his judgment can best serve our



MILFORD B. HATCHER, M.D.

country and our American institutions. Placards have been prepared for you to display so that your patients will know that you are interested in the welfare of this country and that you and your employees are going to participate in electing officials and help to shape the years ahead.

President, Medical Association of Georgia

NEW MEMBERS OF THE MAG

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Avellone, Theodore M.	USAH Ft. McPherson Atlanta 20	DE-4	Fulton
Carey, James Robert	Medical Center Hospital Warner Robins	Active	Peach Belt
Chait, Donald Carl	1938 Peachtree Rd., N.W. Atlanta 9	Active	Fulton
Crawley, William Dukes, Jr.	783 Chickamauga Ave. Rossville	Active	Walker- Catoosa-Dade
Dean, Robert Durley	110 Church St. LaGrange	Active	Troup
Dimon, Joseph H., III	1938 Peachtree Rd., N.W. Atlanta 9	Active	Fulton
Fitzpatrick, Paul E.	220 N. Pentz St. Dalton	Active	Whitfield
Hailey, Chenault W.	711 Doctors Building Atlanta 8	Active	Fulton
Heller, Haskell M.	722 Drayton St. Savannah	Active	Georgia Medical
Johnson, Jay Richard	106 S. Enota Dr. Gainesville	Active	Hall
Kelley, James Marvin	Harbin Clinic Rome	Active	Floyd
Linz, Werner A.	303 Smith St. LaGrange	Active	Troup
Lumpkin, Murray B.	204 W. Waugh St. Dalton	Active	Whitfield
McKay, Hamilton Witherspoon, Jr.	114 Armstrong St., S.E. Atlanta 3	DE-2	Fulton
Martinez, Joseph	Memorial Hospital Waycross	Active	Ware
Moore, William Leroy, Jr.	321 W. 7th Ave. Rome	Active	Floyd
Ochota, Leszek	340 Boulevard, N.E. Atlanta 12	Active	Fulton
Peacock, Ray Lowell, Jr.	108 S. Enota Dr. Gainesville	Active	Hall
Pool, Leland L.	Hall County Hospital Gainesville	Active	Hall
Smith, David Hamilton	340 Boulevard, N. E. Atlanta 12	Active	Fulton
Tanner, Terrell Benson	Dispensary, NAAS Chase Field Beeville, Texas	DE-4	Jackson-Barrow
Thomas, Donald Ray	Chatsworth Rd. Dalton	Active	Whitfield
Toledo, Florentin Humberto	702 N. Greenwood St. LaGrange	DE-2	Troup
Voljavec, Bozidar Franc	Batley State Hospital Rome	Active	Floyd
Voyles, Walter R.	307 Fourth St. Waynesboro	Active	Burke
Wilbanks, James B.	Clarkesville	Active	Habersham
Wood, William Adolphus, Jr.	373 Parkway Dr., N.E. Atlanta	Active	Fulton



current clinical concepts

Absorption and Excretion of Four Penicillins

INTRAMUSCULAR PENICILLIN G remains the over-all most effective method of penicillin administration, and significantly superior to all oral forms of penicillin now marketed.

McCarthy, Clarke G., and Finland, Maxwell, *The New England Journal of Medicine* 263:315, August 18, 1960.

Gross Hematuria Due to Microlithiasis

MICROLITHS RUPTURING INTO adjacent blood vessels may be the cause for hematuria of unexplained origin.

Hoffman, C. A., *The Journal of Urology* 84:201, August, 1960.

The Clinical Use of Renacidin in Urinary Calcifications

RENACIDIN HAS BEEN used to dissolve urinary calcification with encouraging results, and without serious side effects.

Mulvaney, William P., *The Journal of Urology* 84:206, August, 1960.

Ice Water as Primary Treatment of Burns

WHERE IT IS POSSIBLE to apply ice cold compresses, burn cases obtain immediate relief of pain and may experience a decrease in the incidence of infection.

Shulman, A. G., *J.A.M.A.* 173:1916, August 27, 1960.

Amelioration of Diabetes Mellitus After Pituitary Infarction

EVIDENCE CONTINUES to accumulate that hormones other than pancreatic insulin are involved in the metabolic and endocrine activities that are responsible for diabetes mellitus. Pituitary infarction may result in the amelioration of diabetes, and while rare indeed it is a significant observation.

The New England Journal of Medicine 263:374, August 25, 1960.

Neonatal Gangrene

NEONATAL GANGRENE of one or more extremities is a real, but admittedly, unusual entity. Upwards of 96 cases have been reported in the English-speaking litera-

ture. When it exists, the majority present themselves in the first few days of life. The usual course is the development of cyanosis and coldness in an extremity after a short preliminary period of blanching which may or may not be observed. Cyanosis deepens, edema appears and progresses. Peripheral pulses may, or may not, be felt. The skin vesiculates; a sharp line of demarcation develops. Interesting enough, short of demarcation, spontaneous reversibility may occur.

Selected authors.

Acute Recurrent Intussusception

ACUTE RECURRENT INTUSSUSCEPTION occurs in one to two per cent of cases. When noted, it appears that recurrence is most apt to appear within a few months of original experience. The etiology of this acute recurrence can be just as obscure as the original. The so-called "currant jelly" stool is not necessarily present in recurrence. Usually all the other manifestations for diagnosis exist, however.

Recurrence is managed in a similar fashion to the original problem—reduction by barium enema or at laparotomy. One patient is reported to have had simple reduction performed three times.

Personal communication.

Health Insurance

DURING THE LAST decade, private plans of health insurance and prepaid medical care have made giant strides in enrollment, so that 71 per cent of all American families now take part in some such arrangement. But this figure is deceptive. The *amount* which all families pay for health is only 25 per cent covered by insurance—a gain of only a few percentage points since 1954.

Straus, D. B.: *Can We Afford to be Healthy?* Harpers, July, 1960.

Illness and Environment

THE EVIDENCE INDICATES that the reaction of a man to his life's situation had an influence upon all forms of illness, and that it plays a role of significance in at least one-third of all episodes of disease, regardless of their nature or location, their cause or their severity. Ultimately, medicine will have to take account of this in the treatment of illness. It is very probable that an

CLINICAL CONCEPTS / Continued

increasing proportion of the therapeutic effort will have to be directed at the patient's relation to his environment, if we wish to make any significant improvement in his health.

Henkle, L. E., Jr. and Wolff, H. G.: Ecologic Investigations of the Relationship between Illness, Life Experiences, and Social Environment. *Ann. Int. Med.* 49:1373-1388, 1958.

Smoking and Cancer of the Stomach

THE DEATH RATE from cancer of the stomach has decreased as strikingly as the death rate from cancer of the lung has increased. It will be noted that for males the decrease in the death rate from cancer of the stomach is not quite as much as the increase in the rates for cancer of the lung, but in females the decrease in rate for cancer of the stomach is greater than the increase for cancer of the lung. If the rise of the death rate from cancer of the lung must be attributed to an environmental factor the intensity of which has been increasing in this period, specifically something inspired into the lung, was not the same "logic" attributed to fall in death rate from gastric cancer to something ingested in the stomach? If so, surely it is important to discover what it is, for then we shall have, not a cause of cancer, but a cure.

Berkson, J.: Smoking and Cancer of the Lung, Proc. Staff Meeting, Mayo Clinic 35:367-385, 1960.

Smoking and Cancer of the Lung

IF 85-95 per cent of a population are smokers, then the small minority who are not smokers would appear, on the face of it, to be of some special type of constitution . . . (If they) successfully resist the incessantly applied blandishments and reflex conditioning of the cigarette advertisers, they are a hearty lot, and, if they can withstand these assaults, they should have little difficulty in fending off tuberculosis or either cancer.

Berkson, J.: "Smoking and Lung Cancer: Some Observations on Two Recent Reports, *J. Am. Statist. A.* 53:28-38, 1958.

What Is an Internist?

INTERNISTS WORK UNDER the handicap of lacking a suitable name . . . Most insurance companies, including Blue Shield, do not recognize the internist as a specialist . . . Through their linguistic heritage the English-speaking people have obtained a long-accepting words which can't express to the layman the functions of an internist. The term "physician" has an honorable and ancient history. In one sense, it means "a person who heals," emphasizing the therapeutic aspects of internal medicine. A special meaning developed as "one who treats with drugs rather than with surgical procedures" . . . The general practitioner has long assisted in educating the layman to this distinction by representing himself as "physician and surgeon." "Physician" has been accepted as synonymous with "internist" in the titles of the Association of American Physicians and the American College of Physicians . . . but an ad-

jective is required to distinguish between the physician-and-surgeon and the person who specializes in internal medicine. Any English dictionary contains rich treasure for our purpose under the word "master." The word has several meanings, all pertinent to the present problem. It may mean "one who controls or governs," such as in "Master Mariner." In this sense it can refer to the function of the internist as a doctor who serves the patient in a comprehensive capacity and referees the recommendation of the narrower specialist. "Master" also designates a superior teacher, hence it has come to repute scholarship . . . Thirdly, "master" has long been employed to indicate exceptional skill and performance . . . Cesingley, the standard dictionary of the English language defines "master" as "one who is familiar with all the details of an art, profession, science or trade" . . . I suggest, therefore, that the American College of Physicians or the American Board of Internal Medicine approximate the term "Master Physician" and accord the title to those who are skilled in internal medicine . . . Qualified surgeons encounter a problem similar to that of the internist when they attempt to differentiate themselves from the general practitioners who perform operations on patients. Either the American College of Surgeons or the American Board of Surgery should appropriate a stricter term "Master Surgeon" to those who have been thoroughly qualified. Perhaps the internists and surgeons together can apprise the layman of their superior training and skill by publishing the valuable "Master."

DeGowin, E. E., ed: A Name for the Internist, *Bull. Am. College of Physicians* 1:145-146, 1960.

Euthenasia

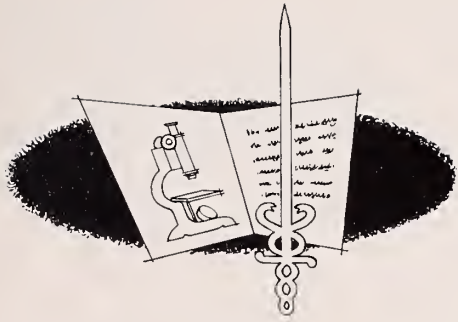
ASIDE FROM THE religious aspects of the care of the incurably ill or the dying, another and most interesting factor has been injected into our ethical concepts concerning this problem by agencies of our government during the past few years. This has to do with the complete about face in policy, relative to the care of casualties resulting from a nuclear attack on this country. The current policy is to treat definitely the lightly injured *first* and the surviving seriously injured *last*, which means of course that there would be few seriously injured survivors after an attack. This is exactly the opposite point of view which had been held relative to the treatment of casualties in all previous wars in which our country has been engaged. The extraordinary fact is that this new policy has been accepted by the medical profession of this country without dissent or even much discussion. Its implications were too self-evident.

Long, P. H.: On the Quantity and Quality of Life, *Medical Times*, May, 1960.

First Branchial Cleft Sinus

DR. DEBORD REPORTS two additional cases of first branchial cleft sinuses. A draining sinus high in the neck, associated with the discharge from the ear, should suggest the proper diagnosis. Permanent cure requires complete dissection of the tract to its origin at the external auditory canal.

DeBord, Robert A., M.D.: First Branchial Cleft Sinus, *Arch. Surg.* 81, 1960.



cancer page

X-RAY THERAPY

John L. Barner, M.D., *Athens*

ONE OF THE modalities in the treatment of cancer and the allied diseases is radiation therapy, and the roentgen ray or x-ray is undoubtedly one of the most powerful physical agents available for treatment.

After the discovery of x-ray by Roentgen in 1895, it was nearly 40 years for this valuable adjunct to medical science to develop into its proper place in the treatment of diseased tissue. Quite naturally, cancer, the most resistant of treatment problems in the medical field, has received the greatest attention.

Cancer alone accounts for 265,000 deaths a year in the United States, which is discouraging, but it would be much worse were it not for x-ray and the other forms of radiation therapy.

X-ray therapy, because of its powerful effects, should only be administered by one well trained and familiar with its physical and biological behavior. Not all tissues are affected the same, nor do all stages of diseased tissue or cancer respond the same. Radiosensitivity and radioresponsivity are, therefore, not synonymous.

X-ray therapy in controlled doses may be used for its anodyne effect, bacterial control, stimulating action, and anti-inflammatory conditions in the dermatological field.

It is difficult to predict the action of x-ray therapy on tissue, for its benefits are attributed to its effects on different cells and stages of growth. Irradiation

may produce fragmentation of chromatin, increased permeability of cell wall, alteration in metabolism and reaction of cell protein solution, and this complex damaging change is more noticeable in cancer cells than normal cells.

More is known of its selective action on certain types of cells and this alone in many cases governs the type and amount of treatment the radiologist decides to give. For example, lymphoid tissue is more sensitive than muscle, muscle more than bone, and the least affected is nerve tissue.

Great strides have been made in the x-ray equipment. The old time exposed tube and aerial conducts are all but forgotten. New shock-proof equipment designed to protect patient and personnel from stray radiation, electrical improvements enabling greater and more constant voltage, and electronic and mechanical changes to more safely control the x-ray energy, are now standard on all equipment. Voltage ranges of therapy today are from 140 KV to several million volts. There are fixed installations, rotational and pulsating equipment, all designed for specific types of treatment. With our better understanding of this form of radiation, tumorcidal doses can be administered more thoroughly than ever before.

X-ray is administered for treatment on calibrated machines and the unit of dosage is the "roentgen,"

Approved by Professional Education Committee, Georgia Division, ACS

symbolized by "r." The total dosage outlined for a treatment is carefully calculated and then given according to one of the prescribed plans, i.e., protracted saturation (Pfahler), fractionated, protracted-fractionated (Coutard), continuing course (Heublein), or variations of these plans.

The reactions resulting from treatment are sometimes pronounced. Skin changes in the area through which x-ray is administered may vary from a slight

erythema to a severe weeping epidermitis. Healing of these reactions may show no permanent changes or may result in slight scarring or telangiectasia. Every consideration for cosmetic appearance is considered, but in treating cancer this is often secondary.

Be it remembered that cancer is curable and until we have a preventative, the greatest number of cures will result from these early diagnosed and early treated with an acknowledged, accepted form of treatment.

FEDERAL—STATE PROGRAM FOR NEEDY AGED

THE FEDERAL GOVERNMENT is offering states liberal matching funds to provide health care for needy and near-needy persons 65 years of age and older.

The program, which Congress approved in the bobtailed post-convention session, is supported by the American Medical Association and allied health groups.

Congressional approval of the federal-state program marked a victory for the medical profession and a defeat for Democratic Presidential Nominee John F. Kennedy, the AFL-CIO, and other advocates of the Social Security approach to the problem.

In a key vote on the issue, the Senate rejected by a 51-44 vote a Kennedy proposal that would have provided hospitalization and medical care for the aged under the Social Security system. The Kennedy plan would have required an increase in payroll taxes.

Republicans and Southern Democrats joined in the Senate to defeat the Social Security approach which was opposed vigorously by the medical profession.

After voting down the Kennedy plan and a separate proposal of the Eisenhower Administration, the Senate passed a modified version of a House-approved program. The modifications, sponsored by Sen. Robert S. Kerr (D., Okla.) and others, provided for increases in the percentage of federal matching funds and for administrative changes designed to facilitate state participation.

Under the legislation as signed into law by President Eisenhower, (1) substantial increases are authorized in federal grants to states to help with health care expenses of the 2.4 million persons on old age assistance rolls, and (2) Federal matching funds are offered the state to finance a new program of health care for an estimated 10 million aged persons, who are not on relief but whose incomes may be inadequate to take care of all their health costs.

Start of the program was authorized for October 1, 1960, for those states where new state legislation is not required.

Administration of the program rests entirely with the states, subject to Federal approval in broad terms. It is

up to each individual state whether it participates. Eligibility standards for beneficiaries and what health care services are provided are matters for the states to decide.

If a state so chooses, it can take care of all the health needs of an eligible beneficiary. The law authorized inpatient hospital services; skilled nursing home services; physicians' services; outpatient or clinic services; home care services; private duty nursing services; physical therapy and related services; dental services; laboratory x-ray services; prescribed drugs, eyeglasses, dentures, and prosthetic devices; diagnostic screening and preventive services, and any other medical care or remedial care recognized under state law.

For medical expenses of persons on old age assistance rolls, the federal government will contribute 50 to 80 per cent—with states with low per capita income getting the larger percentages of federal aid—of an amount equal to \$12 multiplied by the number of old age assistance recipients in a particular state.

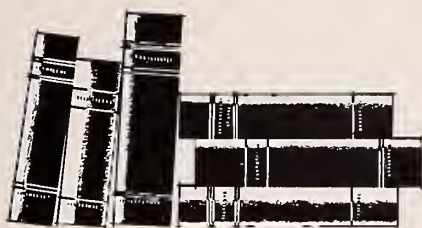
The matching formula will be the same for financing the health care of the near-needy but there is no \$12 limitation figure.

Health, Education and Welfare officials estimated first-year costs of the program of \$262 million—\$202 million federal and \$60 million state. Annual costs are estimated to rise by the end of the fifth year to \$340 million federal and \$180 million state. However, these estimates admittedly are no more than educated guesstimates because so much depends upon state action.

It was estimated that maximum participation and a state contribution of \$989,000 would bring Georgia 4.8 million dollars in federal matching funds in the first year of the program.

The medical-care-for-the-aged legislation was included in an omnibus measure titled Social Security Amendments of 1960. It also eliminated the age 50 requirement for eligibility for disability insurance benefits.

The Senate knocked out of the House bill a provision that would have brought physicians under Social Security coverage.



physician's bookshelf

BOOKS RECEIVED

Douthwaite, Arthur H., M.D., F.R.C.P., **FRENCH'S INDEX OF DIFFERENTIAL DIAGNOSIS**, The Williams and Wilkins Co., Baltimore, Md., 1960, 1111 pp., \$24.00.

Anderson, W.A.D., M.D., F.A.C.P., F.C.A.P., **SYNOPSIS OF PATHOLOGY**, The C. V. Mosby Co., St. Louis, Mo., 1960, 876 pp., \$9.25.

Wolstenholme, G.E.W., O.B.E., M.R.C.P. and O'Connor, Maeve, B.A., **CELLULAR ASPECTS OF IMMUNITY**, Ciba Foundation Symposium, Little, Brown and Co., Boston, Mass., 1960, 495 pp., \$10.50.

Levine, Harold D., M.D., **CARDIAC EMERGENCIES**, Landsberger Medical Books, Inc., New York, N. Y., 1960, 381 pp., \$12.00.

Page, Ernest W., M.D. and Stevenson, Charles S., M.D., **CLINICAL OBSTETRICS AND GYNECOLOGY**, Vol. 3, No. 2, Paul B. Hoeber, Inc., New York, N. Y., June, 1960, 261 pp., pub. quarterly, \$18.00 per year.

REVIEWS

Guttmacher, Alan F., M.D. and Rovinsky, Joseph J., M.D., **MEDICAL, SURGICAL, AND GYNECOLOGICAL COMPLICATIONS OF PREGNANCY**, The Williams and Wilkins Company, Baltimore, Md., 1960, 619 pp., \$16.50.

THIS BOOK, CONTRIBUTED by some 68 members of the staff of the Mount Sinai Hospital, New York City, and edited by Guttmacher and Rovinsky, will find a most useful place in the armamentarium of the obstetrician. It should, also, prove of great value to physicians in other specialties who are called upon to give aid and opinions in the management of pregnancies complicated by coincidental disease.

Almost every conceivable disease which could be encountered in a pregnant woman is discussed by the author in detail. The effect of the disease on the pregnancy and in turn the effect of the pregnancy on the disease are thoroughly covered. The question of therapeutic abortion and maternal sterilization in these situations is intelligently reviewed.

One of the most timely and interesting chapters in the book is that dealing with the effects of radiation, both therapeutic and diagnostic, on the pregnant woman, the fetus, and their progeny. The hazards of radiation, including its genetic and somatic sequelae, are adequately discussed.

The editors of this volume have compiled a veritable

storehouse of information which is presented in a most interesting and concise style. This book is not intended to replace the standard textbooks of obstetrics, but to supplement them as a source of reference.

William C. Helms, M.D.

Millman, Milton, M.D., **PARDON MY SNEEZE, THE STORY OF ALLERGY**, Frye and Smith, Ltd., San Diego, Cal., 1960, 215 pp.

THIS BOOK IS A guide for the individual who wants an explanation in lay terms of the facets of allergy (the allergic state and mechanism, the diagnosis of allergy by history, physical examination and laboratory tests, how treatment is given in allergic disease, how food and respiratory allergies are manifested and produced).

Part Three contains a number of valuable sections on how food diaries are kept, how allergens are controlled environmentally, how foods are contacted unknowingly, and menus and recipes for elimination diets. The author makes an important point in that the patient should be completely informed of what the allergist is doing so that he may cooperate.

The book does have some shortcomings in that the author makes unwarranted claims for allergy in attributing headaches, all kinds of gastrointestinal symptoms and disorders, weakness, lethargy, menstrual disturbance, and gall bladder disfunction as being due to allergic causes, and when he expresses the belief that 60 per cent of the population suffers from food allergy.

In general, this book does what it set out to do. That is to give the patient an insight into allergy. It is therefore, recommended. The inconsistencies and incorrect statements do not involve very important points and are not likely to interfere with the patient's essentially correct interpretation of allergy as pertaining to diagnosis and treatment. This book is not to be sneezed at!

Carl C. Jones, Jr., M.D.

Marti-Ibanez, Felix, M.D., **CENTAUR, ESSAYS ON THE HISTORY OF MEDICAL IDEAS**, MD Publications, Inc., New York, N. Y., 1958, 672 pp., \$6.00.

OPEN THIS BOOK at any one of its 672 pages and you will take off on the wings of prose as exciting as a modern detective story, and as beguiling as the poetry of Shelly or Keats. How far you will be carried on the wings of Ibanez's genius will depend on the demands of your practice. Seldom has this reviewer experienced a medical-literary sojourn as pleasant as the hours spent

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.



*attains
sustains
retains*

*extra
antibiotic
activity*

DEC

attains activity
levels promptly

DECLOMYCIN Demethylchlortetracycline attains — usually within two hours—blood levels more than adequate to suppress susceptible pathogens—on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

sustains activity
levels evenly

DECLOMYCIN Demethylchlortetracycline sustains through the entire therapeutic course, the high activity levels needed to control the primary infection and to check secondary infection at the original—or another—site. This combined action is usually sustained without the pronounced hour-to-hour, dose-to-dose, peak-and-valley fluctuations which characterize other tetracyclines.

TETRACYCLINE
ACTIVITY
WITH
DECLOMYCIN
THERAPY

DOSAGE
150 mg. q.i.d.

TETRACYCLINE
ACTIVITY
WITH OTHER
TETRACYCLINE
THERAPY

DOSAGE
250 mg. q.i.d.

DECLOMYCIN—SUSTAINED ACTIVITY LEVELS

OTHER TETRACYCLINES—PEAKS AND VALLEYS

POSITIVE ANTIBACTERIAL ACTION

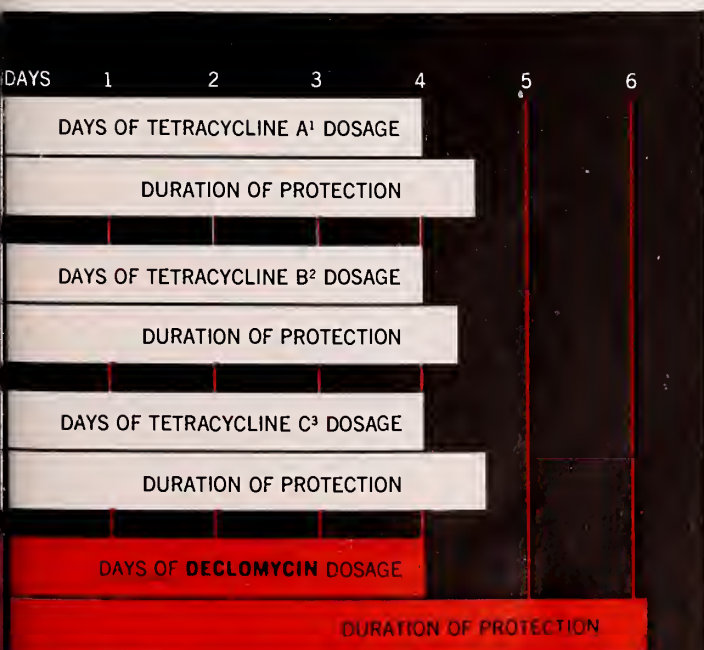
◦ PROTECTION AGAINST PROBLEM PATHOGENS

LOMYCIN[®]

DEMETHYLCHLORTETRACYCLINE LEDERLE

retains activity
levels 24-48 hrs.

DECLOMYCIN Demethylchlortetracycline retains activity levels up to 48 hours after the last dose is given. At least a full, extra day of positive action may thus be confidently expected. The average, daily adult dosage for the average infection—1 capsule q.i.d.—is the same as with other tetracyclines...but **total** dosage is lower and duration of action is longer.



(1) Oxytetracycline. (2) Chlortetracycline. (3) Tetracycline.

PROTECTION AGAINST RECURRENCE

CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.



LEDERLE LABORATORIES
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PHYSICIAN'S BOOKSHELF / Continued

with this group of essays which the author has chosen to call *Centaur*.

One may relax in the hammock of a yesteryear detective story as Dr. Ibanez weaves the thrilling adventure of William Harvey as he presents to the Royal Society his observations on the structure of the heart in action on April 17, 1616. Or perhaps that physician interested in medical history will revel in the choice morsels that Dr. Ibanez has presented in these *Essays On The History of Medical Ideas*. There is much here, too, to offer the physician interested in another physician's interpretation of art and its relationship to medicine. Who is or where is the physician not interested in at least an introduction into the strange universe of art and artists? Enough is offered in each of these essays to sufficiently tantalize the inquisitive physician to pursue what he has but hardly tasted. "The world was created as a magnificent but chaotic conglomerate forms, colors, sounds, and smells. The cubist painters have recreated the world by converting the original amorphous chaos into a geometric cosmos subject to law and measure. The qualitative impressions of classic art have been converted into quantitative measurements." Braque, Picasso, Monet, Cezanne, and others come to the author's attention and are presented entertainingly to the physician.

The facets of Leonardo da Vinci are those of a Winston diamond. With many the physician is familiar, but nowhere has the Master of the Renaissance been presented more delightfully than in Ibanez's short story on page 541 of *Centaur*. This is the book for the physician's bedside reading 1960.

Peter L. Scardino, M.D.

Moyer, John H., M.D. and Fuchs, Morton, M.D., *EDEMA*, W. B. Saunders Co., Philadelphia, Pa., 1960, 833 pp., \$15.00.

THIS SYMPOSIUM ON salt and water retention was held in Philadelphia last year under the auspices of the Hahnemann Medical College with the assistance of Merck, Sharp, and Dohme. Since the index lists more than 100 participants, it is a thick book but the individual contributions are short. It is divided into eight sections, each consisting of about six papers and a panel discussion. The parts are entitled: "Fluid and Electrolyte Balance," "Pharmacology and the Therapeutic Use of Diuretics," "Iatrogenic Edema," "Hypertension," "Toxemia of Pregnancy and Premenstrual Tension," "Edema of Renal Origin," "Edema Associated with Liver Disease," and "Congestive Heart Failure."

Much of the material is necessarily of transient interest, since it describes work and progress but the book is a good place to look for an account of matters currently interesting students of renal disease: the loop of Henle as a counter-current osmotic multiplier; the regulation of ADH and aldosterone secretion; recent studies with the electron microscope; the movement of water and electrolytes across capillary membranes; function of the juxtaglomerular apparatus, etc. For the most part, however, the book is directed at the clinician who must manage dropsical patients with diseases of the heart, liver, or kidney.

The sections on congestive heart failure and on diuretics will probably be the most popular ones, but not among busy clinicians anxious for help in a tight spot.

It is a reference work, however, that belongs in every library seriously interested in medical physiology.

Thomas Findley, M.D.

Grotjahn, Martin, *PSYCHOANALYSIS AND THE FAMILY NEUROSIS*, W. W. Norton and Co., Inc., New York, N. Y.

AN ANALYST is presumed to be someone who has profound knowledge about the limited area of the individual person. Dr. Grotjahn in his title indicates the broadening of his interest. In the book he indicates the depth of his experience, the freedom of his participation, and the critical character of his understanding of the family.

His case material, which has the intimacy necessary for good reading, is also more valuable because of the authenticity which can only come from personal experience. His portrayal of mother's dream, father's dream, and sonny's dream on the same night is one of the most graphic pictures of the oedipal situation ever written.

Dr. Grotjahn portrays also the beginnings of a new movement in psychoanalysis, which will be very reassuring to the public. The growing conviction that there is "health in us." There is the antithesis of our previous conviction best expressed in the Christian Litany, "There is no health in us." Mayhap, Dr. Grotjahn gained this from his courageous experiment of doing psychotherapy in the home. It has been said that psychotherapists go into group therapy work or therapy with couples or therapy with families because they have become bored with individual interviews. If this is true of Dr. Grotjahn, I hope he gets more bored. The result of his present investigations is exciting. I look forward to their extension.

Carl A. Whitaker, M.D.

Marshall, James, M.D., *DISEASES OF THE SKIN*, The Williams and Wilkins Co., Baltimore, Md., 1960, 944 pp., \$15.00.

THIS IS A WELL written volume, but suffers from the poor binding and poor paragraphing. Thus, while all of the required information is present in the script, it is difficult to come by easily and quickly.

Throughout the book the author uses many Latin and French terms for diseases, which, while common in English and European texts, are not so familiar to our American students and practitioners as are the more simplified, direct English of modern terminology.

While the illustrations, all in black and white, are profuse, many of them present the more severe and grotesque skin eruptions rather than those encountered in general practice of dermatology in the United States. Most of the illustrations are of African natives, and while they show the skin picture in the Negro, it decreases their value for the general practitioner of these United States.

The author's delineation of treatment, in many instances, leaves much to be desired. However, the chapters on the skin diseases usually encountered in the tropics, particularly in South Africa, are very excellent. The descriptions are very full and well illustrated, and this book is of much value as a treatise on tropical medicine.

This volume, therefore, could not be recommended as a text book for American students, or as a desk book for the general practitioner in the United States, but as a reference volume for the diagnosis and treatment of tropical, or semi-tropical disease, it is quite excellent.

Herbert S. Alden, M.D.



mental health page

ALCOHOLISM

Harry R. Lipton, M.D., *Atlanta*

THE MEDICAL DEFINITION of an alcoholic, as distinguished from the social drinker, is one whose drinking harmfully and definitely interferes with one or more of his important life activities. He may lose time from work due to drinking, or the quality of his work may suffer, or his homelife harmony may be disrupted, or he may so speak and generally conduct himself that his reputation and relationship with others suffer.

Next to mental illness, the problem of alcoholism is our number one public health problem. We have in this country 70 million drinkers of alcoholic beverages and over five million alcoholics. One out of every 30 individuals over 21 has a disabling alcohol problem. There are 75,000 alcoholics in the state of Georgia. Slightly over half of all alcoholics have an alcoholic parent. Study reveals that a large percentage of alcoholics are lonely, isolated, introverted individuals who are unable to be emotionally close to others.

There are many types of alcoholics and the need for careful discrimination is important both for actual treatment and placement and for scientific application of the medical statement that alcoholics are sick people. In stating that "alcoholics are sick people," we must break down the generalization. Alcoholism, generally speaking, is symptomatic of psychopathology or illness in the personality functioning. This pathology may be primary or secondary. Physical complications may be in the picture, such as organic brain disease or deterioration, hepatic cirrhosis, chronic gastritis, and circulatory disorders.

Pharmacologically, alcohol acts first as an irritant or excitant, but it is primarily a narcotic and depressant. It depresses the higher brain centers, impairing or removing temporarily the brake-power of

judgment, discretion, and control. Thus, primitive impulses and emotions are set free. Actually, alcohol does not make one "tight," it makes one "loose." Ingested alcohol eventually enters the spinal fluid. There, coming in contact with the cells of the central nervous system, it produces changes in functioning. These are: poorer coordination of thought and body action; diminished acuteness of sensory perception; delayed or weakened motor performance; more frequent errors in precision work, and diminished physical efficiency.

Most of the pathology resulting from excessive indulgence is found in disorders in the neuropsychiatric field. This includes encephalopathies of various types, neuropathies, and behavior disturbances or psychopathology. The latter is evidenced by personality, emotional, or mental deviations from the individual's usual behavior or that commonly accepted as usual by society. The psychopathology is in most cases associated with vitamin deficiencies because of inadequate food intake while drinking. With changes in the cell tissues and a lowered resistance to alcohol, drinking habits, plus time, plus strains of life produce various syndromes of chronic alcoholism.

Each individual alcoholic presents an individual problem and must be treated on that basis. One must first determine what type of psychiatric problem one is dealing with; how much deterioration is present; how serious the extent of the drinking is, and whether the individual really wants help.

There is no single form of treatment for the alcoholic. Drugs alone are unsatisfactory. Treatment, to be successful, must treat the underlying personality disorder. Treating the symptom alone is commonly no more beneficial than giving aspirin or morphine for the headache produced by a brain tumor. We

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

MENTAL HEALTH PAGE / Continued

must always remember that, while many individuals drink to relieve various feelings of discomfort or psychic pain, others drink as part of a more serious psychiatric disorder involving mood-swings or schizophrenic features. The need of thorough examination and understanding of the underlying personality illness or disorder cannot be over-emphasized. Also, considerable therapeutic work with the husband, wife, or other family members is necessary.

No one who has had an alcohol problem can ever again drink "socially." We do not yet know exactly why this is so. There is the possibility of some change in cell tissue or spinal fluid. Experience has proven that once a person's drinking has crossed the line into pathological drinking, he can never "handle alcohol" again. He can reintegrate his personality and sometimes achieve more than in the early, "social drinking" days, but he must be a total permanent abstainer.

1960-61 CALENDAR OF MEETINGS

State

- Nov. 29-Dec. 1—"Fractures in General Practice," Medical College of Georgia, Augusta.
- Dec. 1-2—Postgraduate Course in Ophthalmic Surgery, Emory University School of Medicine, Grady Memorial Hospital, Atlanta.
- Dec. 6-8—"Workshop on Diabetes," Medical College of Georgia, Augusta.
- Jan. 24-26—"Problems of the Newborn Infant," Medical College of Georgia, Augusta.
- Feb. 19-22—Atlanta Graduate Assembly, Biltmore Hotel, Atlanta.
- Feb. 28-Mar. 2—"Management of Your Patient with Vascular Disease," Medical College of Georgia, Augusta.
- May 7-10—Annual Session, Medical Association of Georgia, Atlanta Biltmore Hotel, Atlanta.**

Regional

- Oct. 29-30—Southern Society for Pediatric Research, Vanderbilt University School of Medicine, Nashville, Tennessee.
- Oct. 30-31—Southern Chapter, American College of Chest Physicians, Statler-Hilton Hotel, St. Louis, Missouri.
- Oct. 31-Nov. 3—Southern Medical Association, St. Louis, Missouri.
- Nov. 9-18—Postgraduate Medical Seminar Cruise to the West Indies sponsored by Duke University Medical School, Durham, North Carolina.
- Nov. 17-20—Southern Thoracic Surgical Association, British Colonial Hotel, Nassau, Bahamas.
- Dec. 6-8—Southern Surgical Association, Boca Raton Hotel, Boca Raton, Florida.
- Jan. 16-18—Sectional Meeting, American College of Surgeons, Hotel Dinkler-Tutwiler, Birmingham, Alabama.
- Apr. 9-12—Tennessee State Medical Association, Read House Hotel, Chattanooga, Tennessee.
- Apr. 22-25—Texas Medical Association, Galvez and Buccaneer Hotels, Galveston, Texas.

National

- Oct. 28-29—Society of Pelvic Surgeons, Marriott Motor Hotel, Arlington, Virginia.
- Oct. 30-Nov. 4—American School Health Association, San Francisco, California.

- Oct. 31-Nov. 2—Association of American Medical Colleges, Diplomat Hotel, Hollywood Beach, Florida.
- Oct. 31-Nov. 3—Interstate Postgraduate Medical Association of North America, Pittsburgh-Hilton Hotel, Pittsburgh, Pennsylvania.
- Nov. 3-5—Postgraduate Course in Fractures, The Stanley Hotel, Estes Park, Colorado.
- Nov. 7-11—Postgraduate Course in The Physiologic Basis of Electrocardiography, American College of Physicians, University of Utah College of Medicine, Salt Lake City, Utah.
- Nov. 14-18—Postgraduate Course in Diseases of the Chest, World Medical Association, Park Sheraton Hotel, New York, New York.
- Nov. 27—Second National Conference on the Medical Aspects of Sports, AMA, Statler Hilton Hotel, Washington, D. C.
- Nov. 28-Dec. 2—American Medical Association, Clinical Meeting, Washington, D. C.**
- Dec. 4-9—Radiological Society of North America, Netherland Hilton Hotel, Cincinnati, Ohio.
- Jan. 9-13—Postgraduate Course in Recent Advances in Drug Therapy, American College of Physicians, University of Washington School of Medicine, Seattle, Washington.
- Jan. 9-14—Postgraduate Course in General Practice Review, University of Colorado Medical Center, Denver, Colorado.
- Jan. 12-14—Ninth Annual Cancer Seminar, Arizona Division of ACS, Tideland Motor Inn, Tucson, Arizona.
- Jan. 16-20—Postgraduate Course in Mechanisms of Disease, American College of Physicians, Columbia University College of Physicians and Surgeons, Presbyterian Hospital, New York, New York.
- Feb. 8-11—American College of Radiology, Drake Hotel, Chicago, Illinois.
- Feb. 20-24—Postgraduate Course in Selected Topics in Internal Medicine, American College of Physicians, University of Oklahoma School of Medicine and University Hospitals, Oklahoma City, Oklahoma.
- Mar. 20-24—Postgraduate Course in Medical Technology, University of Colorado Medical Center, Denver, Colorado.
- Mar. 20-24—American Surgical Association, Boca Raton Hotel, Boca Raton, Florida.



heart page

LONG-TERM ANTICOAGULANT THERAPY IN PATIENTS with Myocardial Infarction

H. L. Cheney, Jr., M.D., *Thomasville*

THE PAST DECADE has seen the use of anticoagulant therapy become almost universally accepted in the treatment of myocardial infarction. Its acceptance initially was during the immediate postinfarction period consisting of several weeks following the acute episode. The validity of long-term use of anticoagulants extending over a period of years is much slower being established, but at the present time it is gaining acceptance as a useful procedure in an attempt to prevent recurrence of coronary thrombosis and thromboembolic phenomenon. The difficulty in establishing this procedure arises from the fact that studies must involve large numbers of patients, with adequate controls over many years, before final evaluation can be made. To date, there have been several such studies reported.^{1,2,3} These and similar studies present evidence that long-term anticoagulant therapy significantly reduces mortality and incidences of reinfarction in patients who have had a myocardial infarction.

If long-term anticoagulant therapy is to be used, there are several requirements that must be met. The physician must be experienced in the use of anticoagulant drugs, and he must be in a position to carefully supervise therapy. Adequate laboratory facilities must be available for performance of tests to measure the degree of suppression of the clotting mechanism. The patient must be capable of fol-

lowing instruction, reliable in having the periodic laboratory tests, and fully indoctrinated in the hazards of therapy. He must also be able to bear the financial burden, which over a period of years will amount to a considerable expense.

The anticoagulant drugs commonly employed are hypoprothrombinemic in action. There are several available, the most common being Dicumarol® and Warfarin sodium. The action of these and several others is essentially the same. The physician should become familiar with one of them, its effects, side effects, and dosage schedules, and restrict his use to the one. Heparin, employed by a few clinicians, must be given parenterally and is too expensive to be practical.

During the initial period of anticoagulation, usually immediately following the myocardial infarction and while the patient is hospitalized, the physician can fairly accurately establish the patient's dosage. Upon being discharged from the hospital, the prothrombin times should be performed at weekly intervals for several months or until the maintenance dose is established. Then the tests may be performed at two or three week intervals; however, they should not extend beyond this period under any circumstances.

The most widely used test of anticoagulation today is the Quick's one-stage prothrombin determina-

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

tion. It is relatively simple, is available in most clinical laboratories, and is not too expensive. It is performed with a control, and the desired therapeutic range is suppression of the prothrombin time two to two and a half times the control as expressed in seconds. Usually the control is 12-15 seconds and the therapeutic range being 25 to 30 seconds.

There is an inherent danger in the use of anticoagulants. This may be minimized, however, by adhering to the requirements stated above and observing certain contraindications. A history of recent hemorrhage, especially gastrointestinal hemorrhage or a recent history of active peptic ulcer with or without hemorrhage, should not be anticoagulated. Presence of liver disease, subacute bacterial endocarditis, dissecting aneurysm, and a significant degree of hypertension all represent contraindications to therapy. An emotionally disturbed or irresponsible patient should not be anticoagulated.

Even with close observance of the above precautions, complications will develop, usually in the form of hemorrhagic episodes. These are usually very minor and consist of bleeding from gums, petechiae, and occasional ecchymoses. These usually occur with excessive depression of prothrombin activity and will clear by withdrawing the drugs for several days. Hematuria is also occasionally seen and, if not excessive, only necessitates withdrawal of the drug

for several days. If more serious hemorrhage occurred such as gastrointestinal hemorrhage or intracranial hemorrhage, then active measures to restore a normal clotting mechanism should be taken. These consist of administering vitamin K₁ either orally or intravenously, depending on the urgency of the situation. A normal prothrombin time can be restored in a matter of several hours by these means.

Long-term anticoagulant therapy is today an established procedure. There is a rapidly enlarging body of evidence supporting its value in the management of atherosclerotic heart disease. At the present time, if certain requirements can be met by physician, laboratory, and patient, it may be employed with some degree of enthusiasm. However, until more knowledge is obtained concerning atherosclerosis and atherosclerotic heart disease and until further clinical studies, with the aid of time, establishes the role of anticoagulation in altering the disease process, an open mind must be maintained in regard to its ultimate value.

References

1. An Assessment of Long-term Anticoagulant Administration after Cardiac Infarction: Report of the Working Party on Anticoagulant Therapy in Coronary Thrombosis to the Medical Research Council, Brit. M. J. 1:803-810, 1959.
2. Bjerkelund, C. J.: The Effect of Long-term Treatment with Dicumarol® in Myocardial Infarction, Acta. Med. Scandinav., Supplement 330, 1957.
3. Manchtes, B.: The Value of Continuous (1 to 10 years) Long-term Anticoagulant Therapy, Ann. Int. Med. 47:1202-1209, 1957.

GEORGIA HOSPITAL DIET MANUAL

NEW FINDING IN THE fields of nutrition and diet therapy have made revision of the 1954 Georgia Hospital Diet Manual desirable and necessary. The 1954 edition was the first manual prepared especially for use in the smaller hospitals in Georgia. It was very well accepted and is in use in most of the smaller hospitals in the state. Many nursing homes also use this manual as reference in serving routine and modified diets to their patients.

The original publication was prepared by the Medical Association of Georgia, Georgia Dietetic Association, and Georgia Department of Public Health. The above organizations have again cooperated in preparing materials in the revised 1960 edition of the Georgia Hospital Diet Manual.

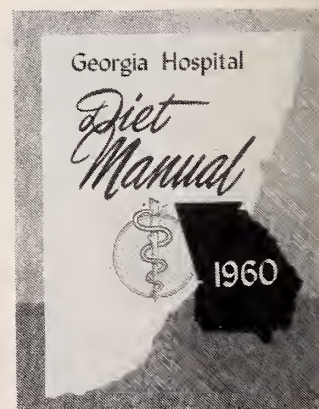
The new manual was printed the latter part of September. Each hospital and nursing home in the state will receive a free copy. One free copy will be available on request to each physician member of the Medical Association of Georgia. If additional copies are desired, they can be secured at a cost of \$1.50 per copy by writing to Central Supply, Georgia Department of Public Health, 47 Trinity Avenue, S.W., Atlanta 3, Georgia.

The new manual contains several diets not found in

the 1954 edition. Most of the diets in the original manual have been modified to comply with new trends and findings in the fields of nutrition and diet therapy. It is hoped that the new manual will meet the needs of the smaller hospitals and nursing homes in the state.

Requests are often received by the Health Department for copies of the diets in the Georgia Hospital Diet Manual. Hospitals and physicians use these diets to instruct the patient who is being dismissed from the hospital. To comply with these requests, reprints of all the modified diets, except the Diabetic Diets, in the new manual will be available.

The reprints are in pad form—20 diets of a kind to a pad. The cost is \$.25 per pad. These diet reprints can be secured by writing to Central Supply, Georgia Department of Public Health, 47 Trinity Avenue, S.W., Atlanta 3, Georgia.



Williams, R. C., M.D., and Uzzell, W. E., Georgia Department of Public Health, Atlanta, Georgia, "Attracting Physicians to Smaller Communities," Hospitals 34:49-51 (July 16) 1960.

In Georgia, a study was made to determine how the establishment of community hospitals in various sized towns affects their ability to attract physicians. This study is based on the experience of 42 new hospitals constructed under the Hill-Burton Program.

These hospitals, when first surveyed, had been in operation for one year. They were constructed between 1949 and 1956 and contained from 14 to 135 beds. Upon completion of their respective hospitals, the communities had populations ranging from 375 to 21,900.

The 42 communities involved in the study averaged 5,566 in population; the new hospitals constructed averaged 41.8 beds and were the only hospitals in their communities. The rural community hospitals averaged 24.4 beds; the town hospitals averaged 30.3 beds. The city hospitals were noticeably larger, with an average of 73 beds.

Ninety-three physicians, an average of 2.21 per community, were attracted during the first year of hospital operation. Only five failed to attract one or more physicians during this first year. Two city hospitals reported attracting nine physicians each.

The typical hospital in the second survey was operating in a community of approximately 5,986 persons; had an average of 44.44 beds, and after having been in operation for an average of six years and seven months, had attracted an average of 4.42 physicians. These 39 older hospitals had attracted a total of 145 physicians. Seventy-eight of these physicians were attracted during the first year of operation and 67 were attracted after the first year of operation.

The hospitals have not only been very successful in attracting new physicians, but also in retaining them. From the opening date of the hospitals until the time of this study, the hospitals lost only 18 physicians. After an average of only six years and seven months of hospital operation, the 34 rural communities experienced a net gain of 145 physicians.

Galletti, Pierre, M.D., and Brecher, Gerhard A., M.D., Emory University, Atlanta 22, Georgia, "Cardiovascular Adaptation to

Partial Heart-Lung Bypass," Cir. Research 8:609-615 (May) 1960.

Partial heart-lung bypass was performed in open-chest dogs, using the gravity arterial infusion technique. Arterial infusion pressure, venous suction and pressures in the left ventricle, aortic arch, and airways were phasically recorded. The mean flow in the aortic arch and the blood content of the extracorporeal circuit were continuously recorded. According to the height of the oxygenator above the heart level, partial heart-lung bypass resulted in a shift of blood either from the extracorporeal circuit into the animal or vice versa. The adjustment of cardiac output to the conditions of decreased venous return was found to obey the following rules: (1) at constant blood volume, the decrease of pulmonary blood flow is proportional to the increase in extracorporeal flow and (2) at constant extracorporeal flow, the variations in pulmonary blood flow are proportional to the variations in body blood volume.

Wenger, Julius, M.D.; Turner, Daniel R., Capt., M.C., U.S.A., and Mendeloff, Joseph, M.D., 5998 Peachtree Road, N.E., Atlanta 19, Georgia, "Homologous Serum Hepatitis Occurring in Laennec's Cirrhosis," Am. J. Digest. Dis. 5:484-492 (May) 1960.

Summary: A known alcoholic with Laennec's cirrhosis (micronodular, portal, or septal) was waiting elective portacaval shunt. The diagnosis of cirrhosis was confirmed by needle biopsy of the liver two months prior to death. During the interval between admission to the hospital and his death, he was observed to abstain from alcohol and maintain a good diet. Approximately four months after several transfusions of whole blood, he developed severe jaundice and died in hepatic coma seven days thereafter.

Postmortem examination confirmed the diagnosis of portal cirrhosis and demonstrated acute massive necrosis of the liver with very few intact hepatic cells. Massive necrosis has not been reported in the natural history of Laennec's cirrhosis; hence, in this patient, it must have been due to an added toxic or infectious agent. The most likely cause of massive necrosis in this case is the agent responsible for homologous serum hepatitis (Virus B). The coexistence of Laennec's cirrhosis and homologous serum hepatitis is not

reported often and even more rarely has it been documented by strict histopathologic criteria for these entities.

Franch, Robert H., M.D., Woodruff Building, Emory University, Atlanta 22, Georgia, "The Clinical Usefulness of the Dye Dilution Curve," South. M. J. 53:821-829 (July) 1960.

The direct recording of indicator dilution curves, using multiple injection sites, in 300 cases studied at cardiac catheterization, has been useful in demonstrating the presence and direction of a central shunt or shunts, and in locating the catheter tip, whether in chambers or great vessels of the pulmonary or systemic circulation or in anomalous channels. Recording the curves is not difficult or time consuming and hence is of value as a simple screening test for significant central shunts.

Simpson, W. G., M.D.; Aarris, Ad; Garson, Warfield, M.D., and Bunch, William L., Jr., M.D., Communicable Disease Center, Public Health Center, Atlanta 3, Georgia, "The Reiter Protein Complement Fixation Test as a Diagnostic Aid in Syphilis," Arch. Dermat. 53:885-895 (July) 1960.

In 1958, 25 years after initiation of the study of untreated syphilis, 209 of the surviving participants were examined. The blood specimens were divided, with samples being tested at the two research laboratories of the Venereal Disease Branch. A battery of ten tests was performed on 204 of the specimens, representing 121 syphilitic patients and 83 controls. Of the syphilitic patients, 56 were classified as "untreated," while the remaining 55 had received an average of six arsenical injections. Results of the test are illustrated in two charts. The reactivity rate of the untreated group ranged from 93 per cent for the Treponema Pallidum Immobilization test (TPI) to 43 per cent for the VDRL slide test. The *Treponema pallidum* antigen tests included in the study apparently retain their reactivity almost indefinitely in untreated syphilis. The Reiter protein antigen tests, however, parallel the nontreponemal antigen tests such as the VDRL in spontaneous reversal to nonreactivity. In the group partially treated with arsenicals, the nonreactivity of the *Treponema pallidum* antigen tests ranged from 11 to 25 per cent; the Reiter protein tests from 53 to 78 per cent; and the nontreponemal anti-

ABSTRACTS / Continued

gen tests from 46 to 91 per cent. A third chart shows data taken from the Serologic Evaluation and Research Assembly comparing results of the TPI, Kolmer test with Reiter treponemal antigen (KRP), and VDRL slide tests in two groups of specimens from patients diagnosed as biologic false positive reactors. Since the Reiter Protein Complement Fixation test is being used in many areas as a diagnostic aid to avoid the comparatively costly TPI test, it should be remembered in interpreting results that the Reiter protein tests, although utilizing a single antigen, can vary with technique and level of sensitivity employed. In syphilis of very long duration, treated or untreated, the chances are that the Reiter tests will be nonreactive more than 50 per cent of the time.

Gelfand, Henry, M.D., M.P.H.; LeBlanc, Dorothy R., R.N., M.P.H.; Potash, Louise, Ph.D.; Clemmer, Dorothy I., Ph.D., and Fox, John P., M.D.; Ph.D., M.P.H., F.A.P.H.A., Communicable Disease Center, Public Health Service, Chamblee, Georgia, "The Spread of Living Attenuated Strains of Polioviruses in Two Communities in Southern Louisiana," *J. Pub. Health* 50:767-778 (June) 1960.

Living, attenuated poliovirus type 3 (Sabin vaccine) was administered orally early in June to all children in a group of families in two lower economic Negro communities in southern Louisiana, which prior serologic study had shown to lack widespread natural immunity to this virus type. At the same time, in a group of similar families chosen to be the indicators of contact infection, a placebo material was fed. Study of frequent, routine fecal specimens from all children served to indicate primary and contact infections. Excretion of homologous virus occurred in 90 per cent of vaccine-fed children, and in 39 per cent of contact children during the succeeding seven weeks. Many concurrent "wild" enterovirus infections were detected. The failure of the vaccine strain to infect a larger proportion of the contact children was attributed in part to viral interference and in larger part

to a lower infectiousness of the vaccine strain as compared with "wild" polioviruses. No illness of any sort could be associated with primary or contact poliovirus infection.

Pruce, Arthur M., M.D.; Clarke, Maurice L. B., M.D., and Climo, Henry J., 1447 Peachtree Street, N.E., Atlanta 9, Georgia, "Exaggeration of Symptoms, Malingering, and Conversion Reaction," *South. M. J.* 53:885-895 (July) 1960.

A discussion of the dissimulator, the malingering and the exaggerator is compared with the patient who has developed an anxiety overlay or a conversion syndrome. The authors point out that a change of diagnosis may be indicated in those cases where proper and adequate therapy has failed to produce expected results within a reasonable period of time. Presumptive tests for evidence of the malingering are presented and a method of differentiation between the malingering and the conversion reactor is outlined.

Factors which influence or motivate the conversion reactor and those affecting the malingering are detailed.

A point is made of the dissimulator, who finds it to his advantage to exaggerate the effects of a *pre-existing* condition, to subdue and to use such abnormal functional or anatomical defect to his advantage.

A psychiatric point of view is presented, in which this author states his belief that the true malingering does not exist and that each case is motivated by underlying psychiatric factors, which are productive of the symptom complex.

Corpe, Raymond F., M.D., and Liang, Joseph, M.D., Battey State Hospital, Rome, Georgia, "Surgical Resection in Pulmonary Tuberculosis Due to Atypical *Mycobacterium Tuberculosis*," *J. Thoracic and Card. Surgery* 40:93-97 (July) 1960.

A series of 25 patients with atypical tuberculosis were subjected to pulmonary resection. All, on admission, were proved to have positive sputum; 22 were non-photochromogenic, two photochromogenic, and one scotochromogenic. At the time of surgery, four of the 25 had negative sputums and the remaining 21 were positive.

Twenty-six resections were performed, since one patient had a bilateral procedure. Four were subsegmentectomies, seven segmentectomies, ten lobectomy alone, two lobectomy plus, and two pneumonectomies. The morbidity rate was 20 per cent and the mortality rate was 12 per cent.

The bacteriological studies of the surgical specimens substantiated the studies of the preoperative sputums. Both the macroscopic and the microscopic appearance of these lesions were similar to those of typical tuberculosis. Twenty-two of the 25, or 88 per cent, were considered treated successfully. Since atypical pulmonary tuberculosis treated medically has shown a sputum conversion rate of about 22 per cent as contrasted to 90 per cent in typical tuberculosis, and a mortality rate of 20 per cent, the authors postulated that patients who are surgical candidates should be subjected to a resection as soon as possible, without waiting for a target point of negativity.

Waugh, William H., M.D., and Shanks, Robert G., M.D., Medical College of Georgia, Augusta, Georgia, "Cause of Genuine Auto-regulation of the Renal Circulation," *Cir. Research* 8:871-888 (July) 1960.

The autonomous ability of the kidney to change its resistance in the face of changed arterial pressure, so that renal blood flow remains relatively constant, was investigated using dog kidneys. The results indicated that active myogenic, rather than neurogenic, vasomotion within the arterial-arteriolar vasculature in response to vascular pressure is responsible for the blood flow autoregulation of the normal kidney. Many of the findings of previous investigations were reconciled with this view. It was further found that blood plasma exerts a vasotonic-potentiating action both in regard to renal circulatory autoregulation and vascular reactivity to drugs. The loss of autoregulation after hemorrhage, which is associated with renal ischemia, was found to be due to contracture or a *vigor intra vitam* of the renal blood vessels. It was, furthermore, suggested that the juxtaglomerular apparatus may act as myogenic pacemakers in the vasomotion underlying the perfect autoregulation of the normal kidney.

ANNOUNCEMENT FOR GENERAL PRACTITIONERS AND INTERNISTS

APPLICATIONS FOR CHARTER MEMBERSHIP in the American Society of Diagnostic Radiology are now being received. Membership is open to GENERAL PRACTITIONERS and INTERNISTS who do or may desire to do some types of Diagnostic Radiology in their offices.

For further information please write:

Louis Shattuck Baer, M.D., F.A.C.P.
411 Primrose Road
Burlingame, California



the association

SOCIETIES

A representative of Hoffman-LaRoche entertained members of the CLAYTON-FAYETTE MEDICAL SOCIETY recently. After dinner, an interesting film of some of the firm's products were shown to the group.

The GEORGIA MEDICAL SOCIETY and the Chatham County Board of Health recently announced plans for a study of Staphylococcus infections.

The THOMAS-BROOKS MEDICAL SOCIETY recently met at the Archbold Memorial Hospital in Thomasville. Following the social hour and dinner, the scientific program was presented by Dr. Harry Prystowsky and Dr. Lamar Crevasse, both of the University of Florida School of Medicine, Gainesville.

Recently the WARE COUNTY MEDICAL SOCIETY met at the Okefenokee Golf Club. Hosts were Arthur M. Knight, Walter E. Lee, and Clayton Mason.

The summer meeting of the TENTH DISTRICT MEDICAL SOCIETY was held in Athens the last of August. The scientific program was presented by Pierce Blitch, Corbitt Thigpen, and G. S. Hinton. Newly elected officers are: president, Pierce Blitch, Augusta; vice president, Ed Maxwell, Thomson, and secretary-treasurer, Charles Wills, Washington.

DEATHS

LEWIS BEASON, 74, of Butler, died unexpectedly August 8 in Americus.

A native of Heflin, Ala., he had lived in Butler since 1932. He had practiced medicine at Darien and Ft. Gaines before moving to Butler.

Dr. Beason was graduated from Emory Medical School in 1912 and had recently served two terms as Butler mayor. He was a member of the Butler Baptist Church, Worshipful Master of Fickling Masonic Lodge, member of Stella Butler Chapter Order of the Eastern Star, and American Legion, and was a Past Master of the Darien Lodge, Ft. Gaines Lodge, and the Third District Masonic Convention.

Survivors include his wife, Mrs. Vera Eugene Beason; a daughter, Mrs. John Turk, Butler; two sons, Capt.

David L. Beason, U. S. Army, Korea and M/Sgt. James G. Beason, Eglin AFB, Fla.; four brothers, Dr. Bill Beason and Howard Beason, Arlington, Claude Beason, Fairfield, Ala., and Clyde Beason, Moultrie; a sister, Mrs. Fannie Hudson, Birmingham, Ala.; six grandchildren, and four great grandchildren.

WILLIAM HENRY HOUSTON, of Colquitt, died August 8 at the age of 73 following a lengthy illness.

Dr. Houston, a native of Sylvester, was educated at the Atlanta Medical College, now Emory University. He moved to Colquitt from Americus and had practiced medicine in Colquitt and Miller County for the last 30 years.

He was a member of the Colquitt Baptist Church and the American Medical Association.

Survivors include two daughters, Mrs. F. P. Davis, Jr., Blakely and Mrs. Charles E. Grow, Colquitt; two sons, Carl Houston, Colquitt and W. H. Houston, Jr., Macon; a brother, John Houston, Sylvester; four sisters, Mrs. Iverson Moree, Mrs. Nellie Powell, Mrs. John Bass, and Mrs. Jewel Crowe, all of Sylvester; eight grandchildren, and a great grandson.

PERSONALS

First District

JOHN MOONEY, of Statesboro, spoke to the Sylvania Rotary Club recently using his classification of surgery as the subject of his talk.

J. W. PALMER, Ailey, was recently featured in *The Atlanta Journal and Constitution Magazine*. Dr. Palmer, now 86 years old, has practiced medicine for 61 years.

HARRY E. ROLLINGS, Savannah, recently returned from Basle, Switzerland and Vienna, Austria, where he attended international medical meetings. As a representative of the American College of Chest Physicians, he lead a discussion for the symposium on the "Diuretic Therapy of Heart Failure."

The First District L.P.N.'s had DAVID ROBINSON, of Savannah, speak on "X-Rays" at one of their recent meetings.

Second District

No news submitted.

Third District

ABRAHAM B. CONGER, Columbus, has been invited to speak on "Management of Diverticulitis" at the Sectional Meeting of the American College of Surgeons, Birmingham, Alabama, January 16-18, 1961.

Fourth District

DR. and MRS. W. P. KIRKLAND, Manchester, recently attended the postgraduate seminar on obstetrics and pediatrics held at Daytona Beach, Florida.

JAMES W. PURCELL, JR., Covington, has been appointed a Fellow in the American Society of Abdominal Surgeons.

Fifth District

PETER HYDRICK, of College Park, has been appointed chairman for the Physicians Committee to work with the Trustees' Building Committee of the Tri-City Hospital Authority.

BERNARD C. HOLLAND, Atlanta, has been appointed the first psychiatrist to serve on the State Board of Health.

DAVID H. SMITH, formerly of Arlington, Virginia, has moved to Forest Park, where he has joined the staff of the Forest Park Clinic.

Sixth District

REECE W. BRADFORD, who recently resigned as assistant superintendent of the Milledgeville State Hospital, has accepted a position with the South Carolina State Hospital.

JAMES W. BURNHAM, JR., of Macon, has announced the opening of his offices for general practice on the Jeffersonville Road.

WILLIAM H. HOLDEN, Macon, recently took a 6,000-mile trip into the South American interior where he visited a few of his former patients.

THOMAS WARTHEN GILMORE, JR., of Sandersville, has joined the Rawlings Sanitarium Clinic, in the practice of internal medicine.

Seventh District

R. D. WALTER, Calhoun, recently presented the program for the Calhoun Rotary Club.

Eighth District

JOHN M. MILLER, of Valdosta, has announced the opening of his office for the practice of gynecology and obstetrics on North Patterson Street.

DUNCAN FARRIS, Waycross, has received accreditation to the American Board of Obstetrics and Gynecology.

The president of The National Foundation in Georgia has announced that VILDA SHUMAN, of Waycross, has been appointed to the volunteer post of state advisor on women's activities.

Ninth District

A clinic on the medical aspects of sports held in Columbus recently was attended by JOHN W. MAULDIN, of Lawrenceville.

Tenth District

CHARLES W. HOCK, Augusta, has been named Georgia state chairman of the World Medical Association.

DR. and MRS. C. H. DICKENS, Madison, recently attended the postgraduate obstetric-pediatric seminar held in Daytona Beach, Florida.

NEW BOARD MEMBER



MAG PRESIDENT, Milford B. Hatcher of Macon, is shown being sworn in as a new member of the State Medical Education Board by Governor Ernest Vandiver at the state capitol in Atlanta recently. MAG's President and Immediate Past President, Luther H. Wolff of Columbus, are ex-officio members of the Board. Other Board members are J. C. Tanner, Jr., Atlanta, Chairman; Herman Dismuke, Ocilla, Vice Chairman, and Hubert Milford of Hartwell. The Board held its regular annual meeting to approve scholarships for the 1960-1961 academic year. Mr. L. R. Siebert is Secretary-Treasurer of the Board.

Executive Committee of Council Meeting Minutes

THE AUGUST MEETING of the Medical Association of Georgia Executive Committee of Council was called to order by Chairman Milford B. Hatcher at 10:00 A.M. on August 28, 1960 at MAG Headquarters Office, Atlanta, Georgia.

The members of the Committee present were: Milford B. Hatcher, Macon, Chairman; Fred H. Simonton, Chickamauga, President-Elect; Luther H. Wolff, Columbus, Immediate Past President; J. G. McDaniel, Atlanta, Chairman of Council; John T. Mauldin, Atlanta, Secretary, and Virgil B. Williams, Griffin, Chairman of Finance. Also present were Edgar Woody, Jr., Atlanta, Editor, JMag; John P. Heard, Decatur, Chairman, Public Service Committee; Mr. John F. Kiser, Atlanta, Associate

Executive Secretary, and Mrs. Catherine Wooten, Executive Assistant, Headquarters Office.

Mr. Kiser read the Executive Committee of Council meeting minutes of July 23, 1960, which were approved as read.

Appointments

(a) *Public Service Committee*: It was voted to appoint Bruce C. Newsom, Columbus, to this committee.

(b) *Poison Control Advisory Committee*: It was voted to appoint Charles T. Brown, Guyton.

(c) *Hospital Relations Committee*: It was voted to appoint A. B. Conger, Columbus, as requested by David Henry Poer, Chairman.

(d) *Georgia State League for Nursing Advisory Board*: It was voted to appoint Joseph B. Mercer, Brunswick.

(e) *Weekly Health Column Committee*: It was voted to appoint Denny Hall, Griffin, and Ferrol Sams, Fayetteville.

Doctors Observance of Election Day

Dr. Woody asked that the Committee consider his plan of asking members to close their offices for a designated period on November 8, 1960, Election Day, so that the personnel and patients may vote. Dr. Hatcher read an editorial written by Dr. Woody on the same subject and this is to be published in the September J_{MAG}.

It was suggested that all doctors put up a sign in their offices stating "No appointments will be made during hours so that the personnel can vote." Dr. Woody suggested putting a yellow sheet in the Journal with the above information on it. Dr. Hatcher recommended that a small poster be enclosed with the Journal for the doctors to place in their offices with above quoted message on it. On motion (Mauldin-Simonton) this was approved.

Hospital Administration Course

Mr. Kiser read a letter from Dr. F. G. Eldridge, Valdosta, to Dr. Hatcher with regard to the discontinuance of the Hospital Administration Program at Emory University with the completion of the present class. It was voted on motion (Wolff-McDaniel) that a letter be written to Emory, as requested by Dr. Eldridge, requesting continuance of the Hospital Administration Course, with a copy to Dr. Eldridge and Mr. Bishop.

Endorsement of Business Agency

Mr. Kiser read a letter from Ware County Medical Society regarding endorsement by MAG of an agency, namely, Medical Business Bureau, in Waycross. On motion (Wolff-McDaniel) it was recommended that this should be left to the local county society because MAG could not endorse such an agency. Secretary Mauldin is to write the county society.

County Society Secretary's Kit and Forms

John P. Heard, Chairman, Public Service Committee, gave a report as follows: Forms are being corrected in order to simplify the work of the county society secretaries. A kit is also to be worked out so a complete record of forms and information may be available for the secretary at all times. Dr. Heard asked for discussion regarding mandatory membership in the AMA. It was recommended that a list be prepared for the next Council meeting of the MAG members who are not members of AMA. President Hatcher recommended that all information be obtained before bringing before Council. Dr. Heard gave an estimated figure of \$2,154.74 for the new forms and kits.

MAG Property and Personnel Insurance

Secretary Mauldin gave a report on the insurance policies: (a) *Fire*—asked permission to increase coverage on furniture and fixtures. On motion (Wolff-McDaniel) the increase was approved; (b) *Travellers liability*—this was discussed regarding staff travel and council member travel. On motion duly made and seconded it was recommended that the liability part of the insurance program be tabled at this time and further information secured. This information is to be sent to President Hatcher.

Hospital Committee Recommendations

Dr. McDaniel read a letter from the Hospital Relations Committee regarding activation of the HIC Program. It was voted to present this to Council for information.

Another letter was read commending the Georgia Hospital Medical Council on the activation of a fine program. This was received for information.

MAG Furniture Disposal

Secretary Mauldin read a letter from J. D. Martin, Jr., Presi-

dent, Fulton County Medical Society, thanking MAG for furniture for Academy of Medicine Building. This was received for information.

Recognition of Editor

Mr. Kiser read a letter from J. W. Chambers, LaGrange, about a speech of his published in the Hogansville Herald. He asked that a letter of thanks to the editor be written by MAG. On motion (Wolff-Simonton) it was recommended that President Hatcher recognize the editor, with a copy to Dr. Chambers.

AMA Resolutions for MAG Implementation

Secretary Mauldin read three resolutions adopted by AMA House of Delegates, June 1960:

(a) *The National Foundation*—On motion (Simonton-Wolff) it was recommended that each county society that has a chapter of the National Foundation in its area be contacted and sent this information.

(b) *Role of Physicians in Public Affairs*—On motion (Wolff-Hatcher) it was recommended that this be published in J_{MAG}.

(c) *Prospective Medical Students*—On motion (Simonton-Williams) it was recommended that this also be published in J_{MAG}.

Finance Committee Report

Dr. Williams gave the financial report. It was recommended that action be deferred on bonds and securities to October Council meeting. Otherwise accepted as read.

Headquarters Office Report

Mr. Kiser gave a report on the (1) Personnel—problems of replacing two secretaries, which are being worked out; (2) Activity—many meetings during month and revision of addressograph plates, etc.

Medicare Report

Secretary Mauldin reported on the administrative problems relating to this department. There is need for an advisor. It was recommended that Dr. Mauldin act as the advisor temporarily. If it requires too much time, someone else will be appointed. Personnel matters were discussed.

Social Welfare Meeting

Secretary Mauldin read a letter requesting co-sponsorship by MAG of the meeting of the Georgia Conference of Social Welfare to be held in February 1961, in Savannah. On motion duly made and seconded, it was recommended that MAG participate in the Conference but not co-sponsor it this year.

Georgia Tax Foundation

Mr. Kiser read a letter from the Georgia Tax Research Foundation, which had been forwarded to Mr. Frank Shackelford for advice, and also read his reply. On motion (Wolff-McDaniel) participation through President Hatcher was approved.

Athletic Injury Conference Report

Mr. Kiser reported on the Conference and it was recommended that Jack Hughston, Columbus, be invited to come to the Council meeting in October to report on the Conference.

Enforcement Plans for Illegal Medical Practice

Mr. Kiser was instructed to mail draft of plan to prevent unauthorized practice of medicine to members of Council before October meeting.

MAG Member Pension Policy

Secretary Mauldin reported on the mailing of a pension check to Dr. G. C. Cole, Dallas, and was instructed to write Fulton County Medical Society regarding continuance of their share.

Unfinished Business

Dr. McDaniel reported that the Treasurer's name was not listed in J_{MAG} as an officer. On motion (Wolff-Simonton) it was recommended to request the Constitution and Bylaws Committee to consider the status of the Treasurer with regard to his duties as an officer.

New Business

President-Elect Simonton recommended that President Hatcher write Bernard Holland a letter of congratulations on being elected to the State Board of Health.

President Hatcher announced that the next Executive Committee of Council meeting has been arranged for October 1-2, 1960, at St. Simons.

There being no further business the meeting was adjourned at 2:00 P.M.

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Dr. C. C. Aven giving a tuberculin test at the Fulton County Health Department. Photograph courtesy of the Atlanta Tuberculosis Association.

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DIABETES MELLITUS IN PREGNANCY

The changes in sugar tolerance which diabetic women undergo in pregnancy are neither constant nor predictable.

Harry Prystowsky, M.D., Gainesville, Florida

PRIOR TO THE ADVENT of insulin in 1921, the great majority of diabetic women were sterile. The underlying cause of this infertility during the pre-insulin era was probably due to a number of factors, most of which are poorly understood. It has been noted, for example, that structural changes occur in the reproductive organs of diabetics, which include disappearance of ovarian follicles and uterine atrophy. Amenorrhea was also common in this period, its incidence having been placed as high as 50 per cent. This evidence of ovarian dysfunction suggests that the infertility of diabetic women in the pre-insulin era was in all probability related to abnormal function of the anterior pituitary gland. In addition to endocrine imbalance, nutritional deficiencies must have entered appreciably into the fertility of diabetics before the insulin era, since the necessarily restricted diets doubtless entailed a marked reduction in food elements essential for reproduction. *When diabetic women did occasionally become pregnant in the pre-insulin era, about one-fourth of the mothers and about a half of the infants died.* The majority of these females died with the characteristic picture of acidosis and coma shortly after delivery.

The experience, prior to 1921, is not merely of historical interest; it is of great clinical import, for it clearly shows that *untreated diabetes and pregnancy are basically incompatible.* On the one hand, the disease, if uncontrolled, so disrupts the reproductive mechanism as to make successful child-bearing almost impossible. On the other hand, untreated dia-

betes is aggravated by pregnancy to a degree which is often fatal. *This mutual incompatibility between neglected diabetes mellitus and pregnancy demands emphasis because, only insofar as the disease process can be meticulously controlled, can its terrible effects on the childbearing woman and her infant be forestalled.*

Incidence

The frequency with which pregnancy is complicated by diabetes has been variously reported between one in 500 and one in 1,000 pregnancies. As you know, the incidence of diabetes increases sharply with age and the maximum susceptibility to the development of the disease in females is not reached until the mid-fifties. This calls to our attention an important clinical fact—*when diabetes is encountered in pregnancy, the chances are greatly in favor of its being met in older women in whom various other complications are more frequent, particularly hypertension.* The age factor, accordingly, will often itself contribute a count against the diabetic gravida.

Diagnosis

The presence of sugar in the urine of a pregnant female may indicate one of three conditions, or any combination of them: lactosuria, renal glycosuria, and diabetes. (Table I)

1. Lactosuria of 100 mgm. per cent or more (a faint Benedict reaction) is not common except for the last six weeks of pregnancy (being seen in only one or two per cent of gravidas prior to that time.) During the last six weeks, however, its incidence increases to seven to eight per cent and to 30 per cent or more on the day before delivery. Of course,

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TABLE 1
Presence of Sugar in the Urine of Pregnant Female

- 1. Lactosuria—(a) Faint Benedict reaction not common except for last 6 weeks of pregnancy.
(b) During last 6 weeks, incidence rises to 7-8%.
(c) Day before delivery, incidence rises to 30% or more.
(d) Most frequent and most marked after delivery.
 - 2. Renal Glycosuria—lowered renal threshold for sugar develops early in pregnancy.
 - 3. Diabetes Mellitus—every patient who shows sugar in the urine should be regarded as a diabetic until proved otherwise.
- Diagnosis is established if the fasting blood sugar is above 120 mgm. per cent on two different occasions.

lactosuria is most frequent and most marked after delivery. *This latter statement must be borne in mind when evaluating the significance of urinary sugar in diabetic patients in the puerperium.*

2. It is well recognized that a lower renal threshold for sugar develops early in pregnancy. Some pregnant patients will show glycosuria with blood sugar levels below 120 mgm. per cent, and glucose may be found rather frequently in the urine shortly after meals. Since both diabetic and non-diabetic gravidas manifest this type of glycosuria occasionally, it is clear that, in the former, *any reliance on urinary sugar in calculating insulin dosage may be very misleading.*

It is an old rule that every patient who shows sugar in the urine should be regarded as a diabetic until proved otherwise. If this rule is not to be followed, diabetics are certain to be overlooked through the erroneous assumption that any urinary sugar found is due either to lactosuria or a lowered renal threshold. *This necessitates routine fasting blood sugar determinations and/or tolerance tests in all pregnant women showing sugar in the urine.* By general consensus the diagnosis of diabetes mellitus is established if the fasting blood sugar is above 120 mgm. per cent on two different occasions.

Effect of Pregnancy on Diabetes

Pregnancy makes diabetes more difficult to control

due to the interaction of a number of factors. (Table 2) These may be briefly stated to be as follows: (1) sugar tolerance is often diminished (more insulin required); (2) sugar tolerance is sometimes increased (less insulin required); (3) vomiting with loss of unknown amounts of carbohydrates may stimulate raised sugar tolerance, may provoke acidosis, and in any event confuses the dietary picture; (4) during labor the muscular exertion and other factors may deplete the glycogen reserve, and sharp alterations in carbohydrate and insulin requirements may occur; (5) an increase in sugar tolerance often occurs after delivery, and hypoglycemia in the puerperium is very common; the latter may be associated with sudden and extreme vascillations in blood sugar, and (6) puerperal infection, even though mild, may precipitate acidosis and coma with great rapidity.

TABLE 2
Effect of Pregnancy on Diabetes

- 1. Sugar tolerance is often diminished (more insulin required).
- 2. Sugar tolerance is sometimes increased (less insulin required).
- 3. Vomiting with loss of unknown amounts of carbohydrate may simulate raised sugar tolerance; may provoke acidosis, and, in any event, confuses the dietary picture.
- 4. Sharp alterations in carbohydrate and insulin requirements may occur during labor because of muscular exertion and other factors.
- 5. An increase in sugar tolerance often occurs after delivery, and hypoglycemia in the puerperium is very common.
- 6. Puerperal infection, even though mild, may precipitate acidosis and coma with great rapidity.

Another factor which may tend to make diabetes more difficult to control, is the increased tendency of pregnant women to become acidotic.

It is important to emphasize that the change in sugar tolerance which diabetic women undergo in pregnancy are neither constant nor predictable, nor are they always in the same direction. In most instances, they are in the form of a lowered sugar tolerance in the latter half of pregnancy. It should be stated, however, that a substantial minority of diabetic patients require less insulin, particularly in the latter part of pregnancy also. Although the



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hypothesis has been suggested that this apparent improvement in diabetes in the latter part of gestation is due to the activity of the fetal pancreas, the evidence in support of this theory is contradictory, and it is not generally accepted.

Acidosis and coma constitute the gravest complication which can befall the pregnant diabetic and her infant. Acidosis is probably more common than generally supposed for it may exist with few or no symptoms. It is generally felt that this "silent acidosis" is the cause of many unexplained fetal deaths and, by general accord, acidotic coma is responsible for almost all maternal deaths in this complication. *The inherent tendency of pregnant women toward acidosis, therefore, is still another count against them and still another reason why diabetes in pregnancy is more difficult to control.*

The Affects of Diabetes on Pregnancy

The affects which diabetes exerts on pregnancy depend in great measure upon *the extent to which the disease is controlled.* If carefully regulated, many of the deadly consequences to the fetus can be eliminated. However, as all studies show, the disease is *potentially* antagonistic to successful gestation and even with the best modern care, the harmful influences of diabetes often make their appearance causing a greatly increased stillbirth and neonatal death rate. Pregnancy is affected by diabetes as follows: (Table 3)

TABLE 3
Effects of Diabetes on Pregnancy

- | |
|--|
| 1. Incidence of spontaneous abortion and premature delivery is perhaps slightly increased. |
| 2. Frequency of toxemia is greatly augmented. |
| 3. Fetal death in utero before the anset of labor is much more common than in normal, non-diabetic patients. |
| 4. Incidence of excess sized infants is many times that met in normal pregnancies. Result—mechanical difficulties in labor are more frequent; cesarean section more often necessary. |
| 5. Hydramnias is more common. |
| 6. Congenital malformations are more frequent. |
| 7. Neonatal period is associated with hazards in form of hypoxia and hypoglycemia of the newborn. |

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|--|
| 1. The incidence of spontaneous abortion and premature delivery is perhaps slightly increased. |
| 2. The frequency of toxemia of pregnancy is greatly augmented. |
| 3. Fetal death in utero before the onset of labor is much more common than in normal, non-diabetic patients. |
| 4. The incidence of excess sized infants is many times that met in normal pregnancies with the result that mechanical difficulties in labor are more frequent and cesarean section more often necessary. |
| 5. Hydramnios is more common. |
| 6. Congenital malformations are more frequent. |
| 7. The neonatal period is associated with especial |

hazards in the form of hypoglycemia and hypoxia of the newborn.

Prognosis

It should be stated that almost all maternal deaths today from diabetes complicated by pregnancy are *due to neglect.*

The prognosis for the fetus, although vastly better than obtained in the pre-insulin era, is still unfavorable *since the lowest perinatal mortality rates reported are of the order of 15 per cent and most range over 20 per cent.* The outlook for the fetus depends in part on the disease pattern of diabetes which the mother presents. Hence, longstanding diabetes, especially when associated with vascular changes, increases enormously the fetal hazard. Furthermore, diabetes which is difficult to control ("brittle diabetes") as well as diabetes in uncooperative patients is a particular threat to the infant.

The classification of diabetic patients according to fetal hazard has been set up by a group at Harvard and is as follows: (Table 4) Group A—glucose tolerance test diabetic; Group B—onset over age 20, no vascular disease, duration zero to nine years; Group C—onset age 10 to 19, duration 10 to 19 years, no vascular disease; Group D—onset under age 10—duration 20 plus years, vascular disease, calcification in legs, retinitis; Group E—patients with calcified pelvic vessel, and Group F—patients with nephritis.

In classes D, E, and F, the perinatal mortality rate approximates 40 per cent.

Management

The main objective in the management of diabetes complicated by pregnancy is *rigid* control of the disease, which is the responsibility of the *internist* who should *share* jointly with the obstetrician the care of *every* such patient. Once the diagnosis is established, the patient should be admitted to the hospital for careful evaluation of the diabetic status,

TABLE 4
Classification of Diabetic Gravida According to Fetal Hazard

- | |
|--|
| Group A—glucose tolerance test diabetic |
| Group B—onset over age 20
no vascular disease
duration 0 to 9 years |
| Group C—onset age 10 to 19
duration 10 to 19 years
no vascular disease |
| Group D—onset under age 10
duration 20 plus years
vascular disease
calcification in legs
retinitis |
| Group E—as group D
calcified pelvic vessels |
| Group F—as group E
nephritis |
| In groups D, E, and F, the perinatal mortality rate approximates 40 per cent. |

DIABETES IN PREGNANCY / Prystowsky

and this patient should be admitted again at different intervals throughout pregnancy for control and subsequent evaluation. Furthermore, visits to the internist and the obstetrician should be made at two week intervals and at each meeting blood sugar determinations should be carried out. It is ideal that before term the patient should again be admitted to the hospital to remain there until after the baby is born. The purpose of this final admission is two-fold: stabilization of the diabetic preparatory to delivery, and consideration of the desirability and possibility of early delivery.

As has been emphasized repeatedly in this presentation, blood sugar levels and not urinary sugar must determine the diet and insulin dosage recommended. Many well-known internists agree that a rather liberal carbohydrate intake is desirable as a preventive against acidosis.

During the first trimester, nausea and vomiting may prevent the patient from adhering to her usual diet and insulin dosage. If vomiting be severe, acidosis may become extreme and control exceedingly difficult. During the last trimester, vigilant observation must be maintained for evidence of shifting sugar tolerance and for signs of beginning preeclampsia. Changes in insulin dosage must be made cautiously since any sharp increases may subject the patient to hypoglycemic reactions. All authorities agree that if an error be made in insulin dosage, it should be in the direction of a slight glycosuria. During labor, because of the glycogen demands on the liver, it is well to give the equivalent of ten grams of glucose every hour or so.

Upon the patient's final admission to the hospital before term, two important obstetric decisions must be made: *when to effect delivery and how*. Because of the tendency of the fetus to succumb as term ap-

proaches, and for other reasons, there is a *widespread but far from unanimous belief* that pregnancy should be terminated by cesarean section at the 38th week. Advocates of section point out that the infant is likely to be large with consequent mechanical difficulties in labor, that such babies with their inherent tendency to hypoxia stand labor poorly, and that this operation forestalls the ever present likelihood of fetal death *in utero*. Against this viewpoint is the contention that diabetics are poor operative risks and that the outlook is equally good with vaginal delivery provided the disease is well controlled.

Actually, once one has established that the diabetes is well regulated, the case should be reviewed in respect to the presence or absence of the following complications: (Table 5) (1) an associated hypertension; (2) a history of previous infant loss; (3) duration of the disease in excess of 15 years; (4) retinitis; (5) an obviously large fetus; (6) hydramnios, and (7) brittle diabetes. If any one of these conditions is present, cesarean section is usually performed, provided x-ray of the abdomen reveals no skeletal abnormalities. If none of these conditions is present, the patient may be allowed to go to term or induced, depending upon the favorability of the cervix. No diabetic gravida, however, should be allowed to go beyond term.

Diabetes may be more difficult to control in the early puerperium than at any other time. This is secondary to wide and sudden fluctuations which the blood sugar sometimes undergoes during this period. Disturbances in sugar tolerance are most common during the first week postpartum, after which the diabetes returns rapidly to its prepregnancy status.

Finally, it is important to mention the work of the group in Boston who have employed stilbesterol and progesterone in the management of diabetic pregnancies together, of course, with meticulous medical and obstetrical care. They believe that most diabetic gravidas suffer from an imbalance of the sex steroids which can be corrected by these ovarian hormones. Their results have been good, but the consensus is that comparable results can be achieved without stilbesterol and progesterone. I should state that this is a question which continues to be one of the major controversial issues in obstetrics.

University of Florida College of Medicine

TABLE 5

Complications to be Considered in Evaluating Methods of Delivery

- | |
|--|
| 1. Associated hypertension |
| 2. History of previous infant loss |
| 3. Duration of disease in excess of 15 years |
| 4. Retinitis |
| 5. Obviously large fetus |
| 6. Hydramnios |
| 7. Brittle diabetes |

**107th ANNUAL SESSION
MEDICAL ASSOCIATION OF GEORGIA**

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Atlanta, Georgia

DIVERTICULITIS OF THE COLON

A Study of Methods of Treatment

A. B. Conger, M.D. and S. A. Roddenbery, M.D., *Columbus*

There is probably no situation in general surgery requiring more seasoned judgment than the handling of this condition.

BECAUSE OF THE AGING population in the United States, diverticulitis and diverticulosis are becoming more common. It has been estimated that between five and ten per cent of people over 40 years of age have diverticulosis.¹ Statistics recently compiled from the University of Michigan indicate that in 14,695 colons examined by barium enema, approximately one out of eight showed the presence of diverticulosis or diverticulitis.² And yet, from the standpoint of the average general surgeon, the disease is relatively rare.

For the purposes of this study, we have reviewed all the cases of diverticulosis and diverticulitis, so diagnosed, at The Medical Center in Columbus, Georgia in the last ten years. These cases number 124. Of these, in 24 cases, diverticulosis was an incidental finding not considered significant. Seventy-two cases had symptomatic diverticulitis not requiring surgery. In only 28 cases was surgery considered necessary. Thus, at a busy 350-bed general hospital, there has been an average of three or less operations for diverticulitis each year during the past ten.

Diverticulitis and its complications, although relatively rare, continue to remain a most serious problem. There is perhaps no situation in general surgery that requires more seasoned judgment than the handling of this condition, if prolonged morbidity and even mortality are to be kept at a minimum.

Diagnosis

The diagnosis of diverticulitis may be very difficult

preoperatively because of the varied manner in which the disease can manifest itself. It can simulate a ruptured ulcer, acute appendicitis, intestinal obstruction, carcinoma of the colon, and acute or chronic cystitis. Of the 28 patients we are reporting on, 18 or almost two-thirds, were operated on as acute emergencies. In 13 of these instances, diverticulitis was not the preoperative diagnosis, but rather the patient was explored for appendicitis. Five of these cases were explored because of a free rupture of the diverticulum into the peritoneal cavity with all signs of an abdominal catastrophe.

In making the correct diagnosis, a high level of suspicion of diverticulitis is helpful. Usually the point of maximum tenderness is in the midline or left lower quadrant in diverticulitis, whereas it is over McBurney's Point in appendicitis.

In the differential diagnosis from carcinoma, a recent study from the Henry Ford Hospital³ compared 100 patients with proved carcinoma of the sigmoid and 100 patients with every reasonable finding supporting the diagnosis of diverticulitis. The two conditions had many signs and symptoms in common. However, certain generalizations about diagnosis were possible. Change of bowel habit, evidence of intestinal bleeding, anemia, and weight loss were more frequent in patients with tumors. Pain, fever, and leukocytosis were more frequent in patients with diverticulitis.

The sigmoidoscope may be very helpful. If a tumor can be seen and biopsied, this is of great value. However, carcinoma of the sigmoid is frequently too high to be seen on sigmoidoscopic examination and it is rarely possible to visualize the involved area in a patient with diverticulitis.

We are forced to rely largely upon the barium enema study in making the differential diagnosis. Unfortunately, in 26 to 33 per cent of cases the

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barium enema study will not distinguish between these two conditions, either because of the equivocal appearance of the lesion or because complete obstruction is present.⁴ It may be impossible to distinguish between carcinoma and diverticulitis, even when the bowel is explored at operation. Yet, at this point, the surgeon must decide, as best he can, whether the lesion is inflammatory or malignant. If he elects to do a primary resection, the operative procedure for carcinoma is quite different from that which is required for diverticulitis. If only a proximal colostomy is to be done, the timing of the subsequent resection is entirely dependent upon whether or not it has been possible to exclude carcinoma.

Emergency Surgery

In 1941 Babcock⁵ made the statement that diverticulitis of the sigmoid is the one disease of an intra-abdominal organ characterized by a tendency to persist or relapse, with perforation, peritonitis, abscess, fistula, or intestinal obstruction for which leading abdominal surgeons still advocate medical measures, and delayed and palliative operations. In general, this is still true here. We have, in the past, operated on patients with diverticulitis only when we were pushed into it as an emergency procedure or when we were wrong in our diagnosis. Of the 124 charts reviewed in this study, 96 required no treatment or were handled medically. Of these, 11 had bled rather severely, five had a mass in the left lower quadrant, and 55 had pain, tenderness and/or other signs of obstruction such as distention, nausea, and vomiting.

Of the 28 patients requiring surgery, five were operated on for acute, free, peritoneal rupture. In four of these cases, the catastrophe was overwhelming and in spite of exteriorization of the bowel in some cases, drainage, and general supportive therapy, the patients died. In the one case that lived, a free rupture was found so low, the bowel could not be exteriorized. A biopsy was taken, the bowel was closed, drainage was instituted, and a transverse colostomy was done.

In 13 cases the patients were explored with a preoperative diagnosis of appendicitis. Eight of these 13 were drained only, and of these, six did well, whereas two had complicated fistulas. In four of the 13 cases, the mass was resected without a colostomy, and of these, three did well with no complications, but one died. In one of the 13 patients, a transverse colostomy was done. This was closed some six months afterwards without bowel resection. The patient still has difficulty with diverticulitis. This shows again that the involved portion of colon must

be removed in order to cure the disease. Generally, the disease recurs in one-third to one-half of those cases in which a diverting colonic stoma has been established first and then closed later without resection, even though in the quiescent interval, it appears that complete healing has resulted.

It is our feeling at the present time that if a diagnosis of diverticulitis is made preoperatively, the patient is to be treated medically with antibiotics, nasogastric suction, and parenteral fluids. When non-surgical means do not result in prompt subsidence of the process, a right, transverse, completely diverting colostomy is indicated, supplemented by incision and drainage of an abscess if present. In some cases in which the diagnosis is not made preoperatively and the patient is explored and a small abscess is found, certainly drainage should be instituted, combined either with a transverse colostomy or not depending upon the extent of the process, the amount of spill into the peritoneal cavity, etc. Although it is possible in many instances to resect unprepared bowel and get by with it, we do not advocate this. It is our feeling that the abdomen should be closed with or without drainage and with or without a colostomy depending on the findings. Later, after proper preparation, particularly if carcinoma cannot be excluded, a definitive bowel resection can be done.

Non-Emergency Surgery

Again here, it has been the practice in the past to operate only for severe complications such as obstruction, fistula formation, etc. There were eight such cases in this study. Of these, four were explored without a colostomy. Bowel was resected with drainage. All recovered, but two of the four cases formed fecal fistulas as complications.

One patient, in this series of eight who were done not as emergencies, had a transverse colostomy first; followed in a few weeks by an exploration. He did well without complications. In one instance, a mass was found in the sigmoid and a Mikulitz resection was done. This patient did well.

One patient with known diverticulitis of the sigmoid was admitted several times with tarry stools. About one year after his original bout of melena, he was found to have a carcinoma of the stomach.

One patient with an x-ray diagnosis of diverticulitis was explored several months later and was found to have a carcinoma of the colon.

One patient was admitted for severe bleeding from her rectum. After a work-up, she was explored and a mass was found in the region of her left ovary. It was diagnosed as diverticulitis and a transverse colostomy was done. She bled through transverse colostomy, and some six operations later, it was found that she had endometriosis causing the bleed-

ing. She is well and healthy at present.

One patient developed an abscess which drained through the rectum.

One patient with a fecal fistula had a resection done without a colostomy. The fistula recurred. A colostomy was done and six months later another resection was done. The fistula still recurred. However, it is gradually healing without difficulty.

Recent Trends in Surgery for Diverticulitis

In recent years there have been many articles, especially from the Mayo Clinic,⁶ which report excellent results from a one-stage, anterior resection of the sigmoid for diverticulitis. Waugh⁷ reports on a total of 320 patients who underwent operation for diverticulitis of the sigmoid between 1945 and 1954. Of these, 93 (29 per cent) underwent one-stage resection with primary anastomosis. These patients were operated on for many and varied reasons, but, generally, 50 per cent had had repeated attacks of diverticulitis, 50 per cent had recorded fever with or without chills, and more than half had obstructive symptoms. Fifty per cent also had a palpable mass either abdominally or rectally. Nineteen of the patients had fistulae. Nine per cent had noted bright blood in the stools. In 25 per cent of the cases there was some question about whether or not the patient had carcinoma.

Of the 93 patients reported by Waugh who underwent one-stage resection, there were 18 complications and only one death. Of the complications, there were five fecal fistulae (four of which healed spontaneously), there were two cases of obstruction, five wound infections, etc. In all, however, the results were excellent and generally better than in the 220 patients for whom multiple-stage operations were performed in the same period. The increased morbidity and mortality rates in the multiple-stage operation group was anticipated because most of the emergency admissions and many of the patients with more acute diverticulitis were included in this group. Nevertheless, it should be emphasized that a large number of the patients who underwent one-stage resection presented more acute and extensive disease at the time of operation than did many for whom a multiple stage procedure was carried out.

A major concern is that of attempting to ascertain the group of patients who will continue to have recurrent, incapacitating attacks leading ultimately to dangerous complications and long term illness. Ideally, recognition of this group should take place at a time when resection can be performed as a one-stage procedure. The main premonitory signs shaping the decision as to early resection for a patient otherwise well are: (1) recurring attacks of abdominal pain

and fever despite good medical management, (2) episodes suggestive of subacute obstruction, (3) evidence of one or more subacute perforations with localized peritonitis, (4) the association of more than minor urinary symptoms, (5) the presence of a mass that does not resolve with reasonable rapidity after antibiotic therapy, and (6) lower intestinal bleeding and the presence of diverticula of the sigmoid after other lesions that might be responsible have been excluded.

Summary and Conclusions

The actual number of cases of diverticulitis is increasing due to the aging population in the United States. However, the average general surgeon may see only a few cases of diverticulitis requiring surgery in his life time.

All of the cases of diverticulitis and diverticulosis so diagnosed in the past ten years at The Medical Center in Columbus were reviewed. Of these, only 28 cases were operated on. Of the 28 patients, five were explored for a massive perforation with a generalized peritonitis. Of these, four died. Thirteen were explored for appendicitis. Eight of the 13 were drained only, with the development of two fecal fistulas. In four cases, an inflammatory mass was resected without a colostomy, and there was one death. In one instance, a transverse colostomy was done with a closure later without a bowel resection. This patient still has difficulty. Of the remaining ten cases operated on for diverticulitis, there were two carcinomas found—one of the sigmoid colon and one of the stomach. One case of severe endometriosis was found after six operations for diverticulitis.

It is thought that about 45 per cent of patients who have one attack of diverticulitis will have subsequent attacks. Thirty per cent of these patients with diverticulitis develop obstruction, perforation, or a fistula. These are most likely to occur in patients who have recurring attacks of diverticulitis, episodes suggestive of obstruction, when there is a significantly narrowed sigmoid colon, if a persistent tender mass develops in the left lower quadrant, in patients who experience distress on urination, or in patients who continue to bleed after other lesions have been excluded.⁴ It is felt that in this group, particularly if they are under the age of 50, an elective, careful operation may well be considered.

As regards emergency surgery, we know of no good way to treat patients who have a massive perforation with a generalized peritonitis. Certainly, the rent in the bowel should be closed, if possible, or exteriorized or a transverse colostomy should be done, and drainage should be instituted. The best possible supportive care should be given, but a con-

siderable number of these patients are probably going to die. In the patients who are explored for appendicitis and a localized area of perforation is found, we believe drainage should be instituted and a transverse colostomy should be done or possibly a Rankin, obstructive type resection might be done if the lesion can be well mobilized. If carcinoma can be excluded, we feel very strongly that six months should go by before the resection is done. The colostomy can be closed either at the time of the resection or within a period of two or three weeks.

The primary treatment of uncomplicated diverticulitis remains medical. However, many complica-

tions might be avoided if earlier and more aggressive surgery were instituted.

206 Doctors Building

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TOP SCIENTIFIC PROGRAM PLANNED FOR MDs AT AMA CLINICAL MEETING

THE 14TH CLINICAL meeting of the American Medical Association in Washington, November 28-December 1, will offer a well-rounded, stimulating scientific program designed to interest both family physicians and specialists. The symposia, presentations, and discussions will stress the theme, "New Developments in Old Diseases and Old Developments in New Diseases."

Participants will include proponents of both sides where different views exist on the management of a disease or medical condition. For example, should tonsils be removed when mildly involved or only when they are badly diseased?

The patient's side will also be heard on one symposium. Clarence B. Randall, an industrialist and special assistant to President Eisenhower, will talk on coronary disease from the patient's viewpoint. Other participants and their topics on this panel are:

A. Carlton Ernstone, *Moderator*, Cleveland, Ohio
Thomas W. Mattingly, Washington, D.C.

"Can Coronary Patients be Predicted by Clinical or Physiologic Measurements?"

Donald S. Fredrickson, Bethesda, Maryland

"Fat Metabolism as a Background to the Development of Coronary Atherosclerotic Disease"

Victor A. McKusick, Baltimore, Maryland

"Genetic Background of Patients with Coronary Vascular Disease"

Eugene A. Stead, Jr., Durham, North Carolina

"Management of the Dietary and Psychologic Problems of the Patient with Coronary Disease"

"The Problem of Management of Nodules," always perplexing for both the specialist and the family physician, will be discussed by three panels concerned with breast nodules, the solitary pulmonary nodule, and nodules of the neck.

Another panel will discuss "Recent Advances of the Use of Antibiotics and Steroids," and additional sym-

posia will cover areas in obstetrics-gynecology, pediatrics, edema, cirrhosis and liver diseases, renal problems, osteoporosis, thyrotoxicosis, eye problems, orthopedic surgery and trauma, clinical nutrition, and bronchopulmonary disease.

Outstanding physicians and research scientists from throughout the nation will conduct the scientific program, and the timetable of discussions has been arranged so that physicians may attend the maximum number of sessions and participate in discussions in the particular fields in which they are most interested.

All the scientific sessions will be held at the District of Columbia National Guard Armory. Starting at 9:30 A.M., Monday, November 28, and running until 11:30 A.M., Thursday, December 1, three sections in both morning and afternoon will be held simultaneously in separate rooms at the Armory. One section will be devoted to presentations of formal papers, another to panel discussions, and the third will be a symposium, all of which have question-and-answer periods.

Another important and integral part of the clinical meeting will be the Scientific Exhibit which will contain approximately 125 exhibits in the Armory. Many of these will relate to such specific subjects as cardiovascular conditions, arthritis and rheumatism, and cancer. Others will be grouped into rather broad areas such as neurology and psychiatry, pediatrics, orthopedics, dermatology, drug therapy, surgery, ophthalmology and otolaryngology, obstetrics and gynecology, and laboratory and clinical investigation. Special demonstration exhibits on "Fractures and Problems in Delivery" will also be included.

Over 100 exhibits will make up the Industrial Exhibition, also in the Armory, where the products, services, and aids provided by industry to physicians and their patients will be on display and staffed by competent and knowledgeable attendants.

ADRENAL CORTICAL STEROIDS IN THE TREATMENT OF COMPLICATIONS OF INFECTIOUS MONONUCLEOSIS

in infectious mononucleosis complicated by severe hepatic involvement, hemolytic anemia, encephalitis, and impending respiratory obstruction, steroids may be lifesaving.

Hyman B. Stillerman, M.D. and Rosemonde S. Peltz, M.D., *Atlanta*

INFECTIOUS MONONUCLEOSIS is usually a benign disease, the etiology of which remains unknown. At times, however, the disease may be prostrating, and death occurs in a small percentage of cases. Complications occur and affect the various organ systems with manifestations that may be listed as follows:

1. Central Nervous System^{1,2}

- (a) Aseptic meningitis^{3,4}
- (b) Encephalitis⁵
- (c) Peripheral neuropathy^{6,7}
- (d) Acute polyneuritis^{8,9,10}
- (e) Optic neuritis, primary¹¹
- (f) Seizures¹²
- (g) Psychosis¹³

2. Hematopoietic System

- (a) Hemolytic anemia^{14,15}
- (b) Thrombocytopenic purpura^{16,17}
- (c) Massive hemorrhage due to splenic rupture^{18,19}

3. Cardiovascular System²⁰

- (a) Pericarditis^{21,22,23}
- (b) Myocarditis
- (c) Minor EKG alterations^{24,25}

4. Respiratory System

- (a) Pneumonitis^{26,27}
- (b) Respiratory obstruction²⁸
- (c) Pleural effusion²⁹

5. Gastrointestinal System

- (a) Hepatitis with jaundice^{30,31,32}

6. Urinary System

- (a) Hematuria³³
- (b) Proteinuria²⁷

Rupture of the spleen, nasopharyngeal hemorrhage, laryngeal obstruction, pneumonitis, and cen-

tral nervous system damage producing respiratory paralysis are responsible for the small number of deaths that occur from infectious mononucleosis.

Hepatitis to some degree, occurs in the majority of cases of infectious mononucleosis and, therefore, cannot be considered a complication in the truest sense of the word. Abnormal liver function tests are detected in approximately 90 per cent of patients with infectious mononucleosis. Jaundice, however, is overt in about five per cent of the patients.³⁴ Generalized toxemia and high fever are often noted as part of the early clinical picture of infectious mononucleosis. These manifestations of the illness may be so severe that the patients become critically ill. Generalized toxemia, high fever for long periods of time, and the subsequent prostration are major considerations in the care of patients with this disease.

At present there is no specific therapy for this illness. Treatment in the majority of cases, therefore, is primarily symptomatic. The most important adjunct to therapy in infectious mononucleosis has been the use of steroids for critically ill individuals. In infectious mononucleosis complicated by severe hepatic involvement, hemolytic anemia, encephalitis, and impending respiratory obstruction, steroids are indicated and may be lifesaving. Three cases manifesting severe complications of infectious mononucleosis are presented. Steroid therapy was used in each instance.

Case I

R. G., a 19-year-old white female, was admitted to the hospital on February 26, 1959, complaining of a sore throat, chills, and fever for two weeks. Despite treatment with penicillin, the illness had become progressively worse. At the time of admission,

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she complained of difficulty swallowing, cough, shortness of breath, and a high fever. The remainder of the history was essentially negative.

Physical Examination

The patient was an acutely ill young white female. The temperature was 101.6°F.; pulse 106; respiratory rate was 24, and her blood pressure was 100/60. The most striking physical findings were in the pharynx. The tonsils were markedly edematous, hyperemic, and approximated each other. They were covered with exudate. The soft palate and uvula were edematous, and the posterior pharyngeal wall could not be visualized due to obstruction of view by these organs. Edema of the soft palate prevented any motion. There was periorbital edema and generalized facial edema. The neck was supple. There was generalized glandular enlargement, the nodes being soft and tender especially in the anterior and posterior cervical chains. The lung fields were clear, but respirations were labored and shallow. There was no retraction of the intercostal spaces. The heart was normal; the liver and spleen were not palpable; a rash was not present, and neurological examination was normal.

Laboratory Studies

Laboratory studies confirmed the clinical impression of infectious mononucleosis. The differential smear revealed 69 per cent lymphocytes of which 43 were atypical. A coagulase negative *Staphylococcus aureus* was cultured from the throat. The diphtheria culture was negative. The heterophile agglutination test was positive in a dilution of 1:64. The differential smears were examined by hematologic consultants who concurred in the diagnosis. Although the heterophile titre did not reach diagnostic levels, the clinical and hematologic pictures were typical of infectious mononucleosis. It was not possible to obtain further heterophile antibody studies on this patient after her discharge. Laboratory data is summarized in Chart I.

Hospital Course

On the second hospital day, the patient appeared moribund and tracheotomy was deemed imminent. The patient was then started on ACTH gel, 25 units being given intramuscularly every 12 hours. She was also given hourly irrigations of 50 per cent glucose to the oropharynx. Parenteral fluids were started, and the patient received Chloramphenicol® 500 mg. every six hours parenterally to cover the possibility of undiagnosed infection. Within 24 hours, the pa-

tient was afebrile and able to swallow. She was then given prednisone orally, 5 mg. every six hours. The dose was gradually reduced. On the eighth hospital day, the patient still had generalized glandular enlargement, and the liver was palpable two finger breadths below the right costal margin. She was discharged after 10 days of hospitalization and has made an uneventful recovery.

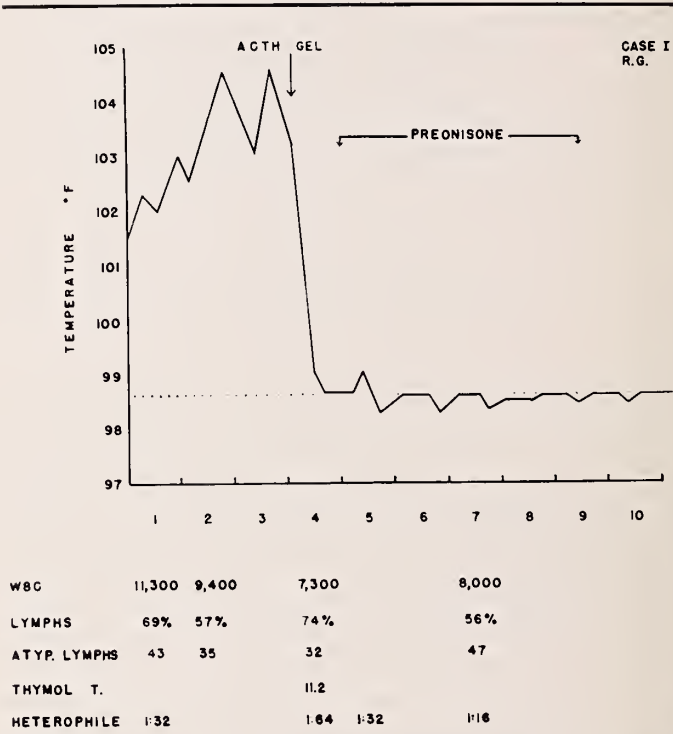


Chart I.

Case II

C. S., a 19-year-old female college student was hospitalized on October 4, 1958. The patient complained of easy fatigability and mild sore throat which had been noted about four or five days prior to admission. She denied fever, chills, night sweats, headache, and abdominal pain. Past history was essentially negative.

Physical Examination

The patient was not in acute distress. The admission temperature was 98.4°F., the pulse 88, and the blood pressure 110/80. Initial physical examination did not reveal jaundice, rash, or petechiae. There was no edema; the neck was supple, and the throat revealed no injection or exudate. The heart was normal and the lung fields were clear. There was slight tenderness to deep palpation in both upper quadrants of the abdomen, but the liver and spleen were not felt. Posterior cervical lymph nodes were enlarged and tender. There was no other lymphadenopathy. Neurological examination was negative.

Laboratory Studies

Admission hemogram revealed a hemoglobin of 13 grams, and a white blood cell count was 3,850.

The differential smear showed 57 lymphocytes; no atypical lymphocytes were noted. The heterophile agglutination was positive in a dilution of 1:256. Chest roentgenogram was negative. The remainder of the laboratory studies are summarized in Chart II.

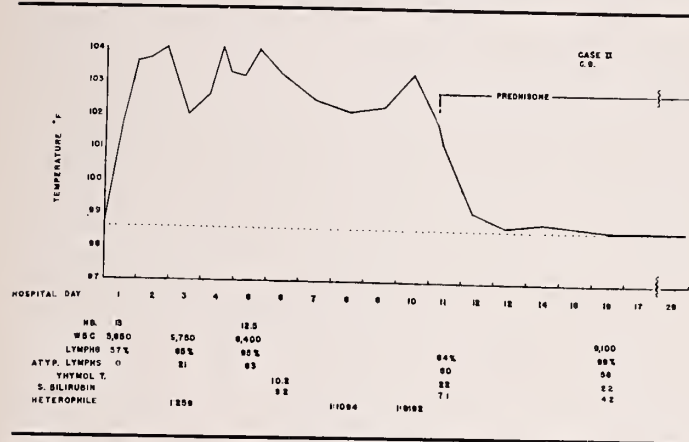


Chart II.

Hospital Course

The patient became febrile on the first hospital day, and fever ranged between 102° and 104°F. for 11 days. During that period of time she became lethargic, had anorexia, nausea, and vomiting. Lymph nodes enlarged progressively and were noted in the axillary, epitrochlear, and inguinal areas. The liver and spleen enlarged gradually until both were felt at the level of the umbilicus. Jaundice was noted on the sixth hospital day, and the urine became dark and the stools pasty white. Since the patient was critically ill, she was started on prednisone 30 mg. daily in divided doses. Within 24 hours fever subsided, and her appetite improved. Prednisone was maintained at 30 mg. for two days and decreased slowly over a 15-day period before it was discontinued. The lymphocytosis was not altered and atypical lymphocytes appeared by the third day. Jaundice deepened. The height of the serum level was 9.5 mg. per cent on the 14th hospital day. The thymol turbidity attained a level of 26.6 units on the 21st hospital day. The heterophile agglutination reached a titre of 1:2048, 30 days after steroid therapy had been started. Serum bilirubin was 1.2 mg. per cent on the 36th hospital day. The patient remained at bed rest for 53 days. Recovery was uneventful.

Case III

The patient was a 20-year-old college student. He was hospitalized on May 18, 1957, with a history of chills, fever, night sweats, headache, myalgia, and a sore throat for 10 days. The fever had ranged up to 104°F. and was unremitant. Two days before admission, the patient developed a dry cough and chest pain. The past history was essentially negative. The patient was admitted to the hospital because of high prolonged fever.

Physical Examination

The patient was not in acute distress. The admission temperature was 102.6°F., the pulse 96, and the blood pressure 115/80. The patient was not jaundiced and no petechiae were noted. The neck was supple; the throat was markedly injected, but no exudate was present. The lymph glands were generally enlarged, tender, and soft. The heart was normal and the lung fields were clear. The liver was palpable and tender. The spleen was not felt. Neurological examination was negative.

Laboratory Studies

Admission hemogram revealed a hemoglobin of 14.4 grams and a white blood cell count of 10,000 with 73 per cent lymphocytes, 15 of which were atypical. Urinalysis revealed a slight trace of albumin and 0-2 hyaline casts/spun HPF. A chest roentgenogram was normal. A heterophile agglutination on this day was positive in a dilution of 1:4096. The thymol turbidity test was 14.1 units. The remainder of the laboratory studies are summarized on Chart III.

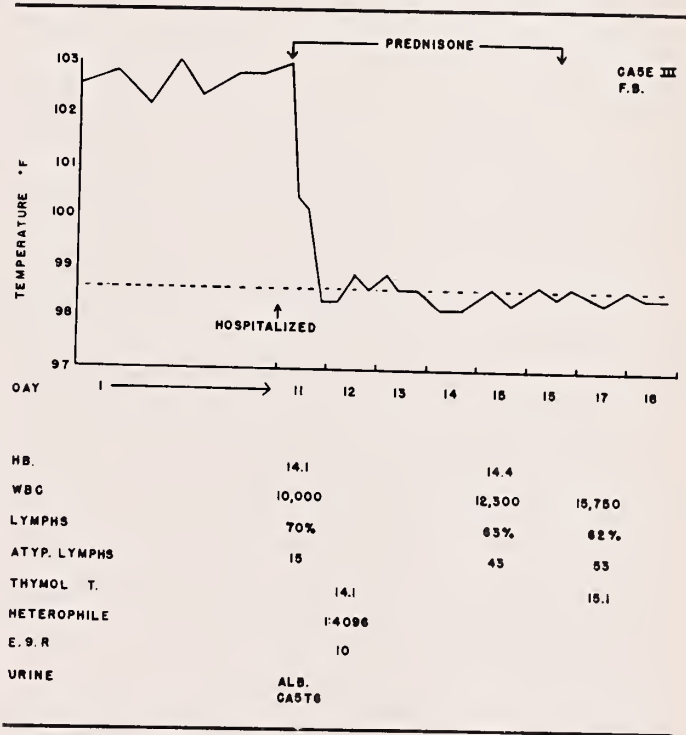


Chart III.

Hospital Course

The patient was started on prednisone, 5 mg. every six hours orally. The temperature promptly fell to normal levels and was normal for the remainder of his hospital stay. He was confined to the hospital for six days and was given 20 units of ACTH gel prior to discharge. The patient returned to school five days after dismissal. He was afebrile, and the thymol turbidity was 12.8 units. The patient was seen again approximately six weeks after the onset of his illness. He had resumed complete activity and complained only of mild pain in the RUQ. Hemo-

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gram, sedimentation rate, and thymol turbidity were all normal. The heterophile agglutination test was still positive in a dilution of 1:1024. He was again examined two months later; had no complaints, and had gained four pounds. The liver was palpable one finger breadth below the right costal margin at this time. The thymol turbidity and cephalin flocculation tests were normal. The heterophile agglutination titre was now only 1:32. Recovery was uneventful.

Comment

Adrenal cortical steroids were first reported for the treatment of infectious mononucleosis in 1951. To date, there have been 43 reported cases in which steroids have been employed. Bayrd has outlined the results of such therapy in 19 cases reported in the literature.³⁵ In 22 of the cases summarized, the results were dramatic in that symptomatic relief occurred in 24 hours. This report concerns three cases of infectious mononucleosis complicated by prostration from prolonged high fever, pharyngeal obstruction, and hepatitis with prolonged fever. In each instance, the patient responded dramatically, and symptomatic relief occurred within 12 to 24 hours. Adrenal corticosteroid therapy was equally effective orally or parenterally. Rebound phenomena did not occur after cessation of steroid therapy. Because of pharyngeal edema, the patient in Case I was unable to swallow. Therefore, therapy was begun parenterally, administering ACTH gel until she had improved sufficiently to take oral medication. Further heterophile antibody studies on this patient could not be followed after her discharge. It is entirely possible that diagnostic titres could have been obtained if the patient had been available for repeated determinations. Cases have been reported in which diagnostic titres have been obtained several weeks after the acute stage of the disease.^{36,37}

Steroids should be given promptly in severe complications of infectious mononucleosis. The dosage of these drugs, of course, must be individualized and is dependent upon the severity of the complication and the response of the patient. Large amounts of steroids are not usually required as the effect occurs rapidly, and clinical symptoms are reduced to a minimum. The dose is gradually reduced and discontinued as the patient improves. Adrenal cortical steroids do not obscure valuable laboratory signs, such as the blood smear, liver function tests, and the heterophile agglutination titre. In Case II, although fever had subsided and the patient had regained her appetite, the heterophile agglutination titre and

thymol turbidity tests continued to rise. These levels were still abnormal two weeks after steroid therapy had been instituted. It is questionable if steroids are effective in shortening the duration of the illness. The authors' experience and that of others³⁸ indicate that the period of disability and convalescence is not altered. Steroids should be used with discretion in the treatment of infectious mononucleosis since it is generally a benign disease. These drugs should be reserved for use only in critically ill patients. The usual contraindications to steroid therapy must be observed. Chest roentgenograms to rule out pulmonary tuberculosis should be a routine procedure. Diagnosis must be accurate in order to avoid masking and spreading severe infections other than infectious mononucleosis.

Summary

Three cases of infectious mononucleosis are presented. In each instance, the illness was severe, the disease being complicated by prolonged fever, hepatitis, and respiratory obstruction respectively. Treatment with prednisone brought about dramatic relief within 12 to 24 hours. Diagnostic laboratory studies remained unchanged by steroid therapy. The length of convalescence was not altered by this type of therapy.

478 Peachtree St., N.E.

Addendum

Since this paper was accepted for publication, two additional cases of severe infectious mononucleosis have been treated with steroids. The clinical impression of infectious mononucleosis was confirmed by laboratory evidence, i.e. typical blood smears and positive heterophile agglutination titers. One patient was treated with ACTH intramuscularly; the other patient received prednisone orally. Both patients responded dramatically with relief of fever, malaise, and weakness within 12 hours. Rebound of symptoms did not occur after cessation of steroid therapy. Convalescence in both cases was uneventful.

The authors wish to express their appreciation to Dr. Thomas Sellers, Jr., for his permission to include one of the above cases

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AMA CLINICAL MEETING SCHEDULES COLOR TELECASTS

SIX ONE-HOUR, COLOR television presentations, originating in Georgetown University Hospital, will be shown at the National Guard Armory during the 14th Clinical Meeting of the American Medical Association in Washington, D.C., November 28-December 1.

The live presentations, televised in a special studio or from operating rooms at the hospital, will deal with dermatology, pediatrics, emergency treatment of major injuries, newer methods in surgical treatment of peptic ulcer, orthopedics, and pathology.

Using patients as examples, physicians will discuss various aspects of diagnosis and treatment.

Brief outlines of the television presentations follow:

Dermatology

Demonstration of common skin lesions on patients and discussion of the cases by two physicians; a review of common skin lesions, their diagnosis and differential points.

Pediatrics

Presentation of mental retardation in children as a treatable disease. Consideration of the three conditions manifesting mental retardation—brain damage, metabolic disease, and special defects. Discussion of the importance of early recognition and the methods for delineation. Outline of treatment of the problems.

Major Injuries

Presentation of methods of approach to the acutely injured patient. Discussion of immediate, emergency care of a group of common serious injuries. Outline in a graphic manner of the lifesaving methods which must be used to cope with these grave situations prior to the definitive treatment.

Peptic Ulcer

Presentation of an operation for the treatment of duodenal ulcer. Operation showing a hemi-gastrectomy, vagotomy, and gastroduodenostomy. Discussion of the indications for surgical intervention and diagnostic criteria leading to operation.

Orthopedics

Surgical clinic on the reconstruction of diseased joints; an operation using compressed polyvinyl sponge for the joint reconstruction. Panel discussion of indications for operation in arthritis and other joint diseases. Presentation of pre- and postoperative care.

Pathology

Presentation of characteristic lesions and x-ray patterns of pulmonary diseases. Graphic illustration of the gross and microscopic pathologic lesions of certain diseases of the lung, including eosinophilic granuloma and infectious pseudo-tumor.

PRESBYCARDIA

Generally, a decrease in cardiac reserve is the major effect of presbycardia.

Walter H. Butler, M.D., *Augusta*

AGE HAS BEEN DEFINED as those changes which are introduced by the factor of time in living. Warthin¹ further considered death as normal or biologic when it resulted from involutionary changes above and stated that in his pathologic experience he had not seen more than 25 such cases. He regarded myocardial atrophy and inadequacy as the most probable natural terminal lesion. Some earlier references to "atrophy of the heart" were made by such men as Jean-Baptiste de Senac (1693-1770) of France, Allan Burns (1781-1813) of Glasgow, and Rene-Joseph-Hyacinthe Bertin (1767-1828) of France. (These references were not always in relation to age, however.)

Broadening of Concept of Cardiac Change

A broadening of this concept of cardiac change concomitant with increasing age was proposed by William Dock in an article in *The New York State Journal of Medicine*, 1945.² He termed aging of the myocardium, presbycardia, to indicate that age has altered the functional ability of the heart even though no significant structural change is apparent.

Dock² states: "While the normal aging or involutional processes in arteries play no significant role in the disorders of advancing years, aging of the heart muscle seems to be an important factor in causing congestive heart failure in middle age and later. This change is not associated with a specific histologic alteration in the muscle and therefore is not fully appreciated. Consequently, there have been various explanations of heart failure with advancing age. All were based on the tacit assumption that age

itself had no appreciable effect on myocardial function."

Tinsley Harrison,³ who has done much to popularize this concept, states: "We believe the most appropriate designation for the condition is senile heart disease."

Dock² further states: "At the extremes of clinical experience are those whose hearts dilate and fail for no other reason than myocardial aging and involution, and those whose hearts, in spite of decades of severe embarrassment, remain efficient into extreme old age."

A few cases of possible pure presbycardia are reported by Levy and Von Glalu⁴ who have noted that "occasionally middle aged people die with huge dilated hearts with no evidence that hypertension, valvular lesions, metabolic disorder, avitaminosis, or any known factor has contributed to heart failure."

More important than these few cases are the cases of clinically evident structural heart disease which causes no difficulty, even with a vigorous life, at the age of 20. Yet, a few decades later, these afflictions are cited as the major cause of cardiac failure in the face of falling basal metabolic rate, decreasing physical activity, and presumably a decreased work load on the heart. There must be some other factor which altered the status quo. In each adult patient with congestive heart failure, "one must decide how much of the difficulty is due to an abnormal mechanical burden, how much to myocardial inflammation, to endocrine or vitamin imbalance, or to coronary sclerosis, and how much to presbycardia."² These statements indicate the importance of the concept of presbycardia.

It was customary in the past to ascribe heart failure of unknown etiology in elderly patients to chronic myocarditis.⁴ Obvious lack of pathological evid-

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ence of this process led the clinical physician to search for another diagnosis to apply to unexplained heart failure. At present, arteriosclerotic heart disease is that diagnosis.

The precedent for this diagnosis is well founded in tradition. Sir James Mackenzie⁵ states, "This picture (angina with progressive CHF) is typical of patients in advanced years with slowly advancing changes in the capillaries and arteries of the heart. ("These Senile Changes".)" Also, one tends to justify this diagnosis by citing the incidence of coronary atherosclerosis in the aged. In postmortem study of 381 cases, in which patients were aged 70 years or more, Willius and Smith⁶ found moderate to advanced coronary atherosclerosis in 75.5 per cent. (In only 2.5 per cent were changes in coronary arteries barely perceptible. Coogan⁷ later found a 12 per cent incidence of essentially normal coronary arteries in 151 autopsies of patients over 70 years.)

Increasing Age and Arteriosclerosis

I think that at present the relationship between increasing age and arteriosclerosis is conceded not to be cause and effect. This was apparent even in 1915 when Allbutt⁸ stated, "We are forced to dissociate aging from arteriosclerosis as the first step toward finding its true etiology." Many factors are now considered to have varying effects on the predisposition to generalized arteriosclerosis; these include diet, hereditary characteristics, sex, stress, and many others.

In recent years the assumption that coronary sclerosis has been disproven. Indeed, Paul D. White⁹ found by observation of thousands of patients over many years that, by and large, persons with sclerosed peripheral arteries, particularly the radials, had not much clinical evidence of coronary atherosclerosis in their early lives, while the great majority of his young and middle-aged victims of coronary heart disease had soft radials. Thus, there seemed actually to be a reversed ratio!

T. R. Harrison³ states: "This diagnosis (ASHD) is presumably based on two assumptions: (1) even though no gross atheromatous lesions may be present in the larger branches of the coronary arterial system, sclerotic changes in the finer branches not visible to the naked eye have compromised the blood supply to the myocardium to such a degree that myocardial failure ensues, and (2) sclerotic changes in the smaller branches of the coronary arteries may progress to the point of causing myocardial failure by virtue of the reduction of blood supply to the myocardium, and yet fail to cause the one characteristic manifestation of myocardial ischemia—angina

pectoris (or myocardial infarction)." In regard to the absence of anginal pain, it is well known that cases of narrowing or complete obstruction of the coronaries may be devoid of pain, but these cases are rare. Concerning cardiac sclerosis there is conflicting evidence. Russek and Zohman¹⁰ have proven with x-ray and perfusion studies "that even in old hearts the vascular bed always grows and adapts itself to the need for blood after infarction or with hypertrophy." Spang, K.,¹¹ however, points out a difference between coronary sclerosis and cardiac sclerosis, which he defines as "arteriosclerotic change of the small coronary vessels associated with myocardial fibrosis." He feels there is a very close relationship between cardiac sclerosis and aging. He feels disturbances of rhythm in the aged are usually dependent on the extent and localization of the fibrosis. Semisch and Louis write that this may be responsible for myocardial ischemia and heart failure¹² as well. Dock,² on the other hand, feels that "there is no basis for diagnosing arteriosclerosis as a cause of heart failure when there has been no coronary narrowing or myocardial infarction." Indeed, French and Dock¹³ reported 80 autopsies of soldiers 20-36 years old who died of coronary occlusion and not one had congestive heart failure of any significant duration. Dock² further states that "even in older patients initial myocardial infarction is followed by heart failure in less than one of ten survivors" and "there is no evidence that myocardial ischemia is a cause of heart failure in the aging or aged (except when there is coronary occlusion)."

Cases Autopsied with Diagnosis of ASHD

Using the criteria of Harrison³ for the diagnosis of ASHD it was felt that cases autopsied at the Eugene Talmadge Memorial Hospital bearing this diagnosis should be reviewed. With this controversy in mind, 42 such cases were deemed to be useful in this study. The results are as follows:

1. Total	42
2. Per cent of total autopsy evidence of moderate or severe atherosclerosis	91%
3. Number with angina	14
4. Number with ECG evidence of myocardial infarction	17
5. Number with both 3 and 4	10
6. Number with either 3 or 4 with severe athero	9
7. Number with either 3 or 4 with moderate athero	7
8. Number with either 3 or 4 with slight athero	4

9. Number with both 3 and 4
negative with severe athero 3
10. Number with both 3 and 4
negative with moderate athero 8
11. Number with both 3 and 4
negative 15
12. Number with both 3 and 4
negative with slight athero 3

The group in which the diagnosis of ASHD is unjustified (11) was found to have a 79 per cent incidence of moderate to severe atherosclerosis. This is not surprising since "among young soldiers killed in action in the Korean War (average age 22 years), 77.3 per cent had gross pathologic evidence of coronary athero."²⁶ This is certainly not a statistically significant difference. The justifications for this diagnosis were based on arrhythmias (8), aneurysm (4), HCVD (2), CVA's (2), embolus (1), and RHD (1). (These were the diagnosis listed which were related to cardiovascular system other than ASHD). The three cases in which atherosclerosis of coronaries were judged to be none or slight (group 12) and no evidence of angina or infarction present had arrhythmias as the only other cardiac related diagnosis. There are no cases which suggest the presence of pure presbycardia. That this is not surprising can be shown by William Dock's own words. In response to Ben Heller's statement, "It must be emphasized that, at the present state of our knowledge, the diagnosis of senile heart disease implies only heart failure of unknown etiology." Dock²⁵ replied: "I agree that heart failure, with no evidence for hypertension, Graves' disease, vitamin deficiency, valvular disease, fibrosis or infiltration by amyloid must be labeled 'Heart failure, cause unknown.' *In my experience, old people do not go into failure without a precipitating cause, but some of them fail with minimal cause—as for example, levels of hypertension, under 40 years of age.*"

"The increased incidence of failure with age is not merely due to the presence of one of these disorders, but to senescence of the myocardium."²

Histologic Myocardial Changes

Histologic myocardial changes concomitant with aging are well known. There is a complete lack of correlation between these findings and predisposition of dilatation and failure. Dock² states, "Since avitaminosis and some endocrine disorders cause failure of the best heart with minimal histologic change, involution may act in an analogous fashion." That is to say on a biochemical level.

The histologic lesions concomitant with age are:

(After A. J. Carlson¹⁵ and William Dock.²)

(1) Atrophy and disappearance of muscle cells which are replaced by adipose tissue or delicate fibrous strands (most marked in auricles and right ventricles and in obese oldsters dying without heart failure).

(2) Tortuous dilated epicardial vessels and sclerosis of annulus fibrosis and tips of papillary muscles (seen commonly when there is no evidence of heart disease).

(3) Accumulation of pigment granules near nuclei of muscle cells which may give chocolate color to myocardium (most common in atrophic hearts of very old persons who never had signs of heart failure).

(4) Increase in subepicardial fat.

(5) Thickening of endocardium.

(6) Loss of protein elasticity.¹⁶

Effects of Aging on Cardiac Function

There are important effects of aging on cardiac function. It is very difficult to separate the effects of subtle pathologic lesions from the effects of senescence, *per se*, however. Generally speaking, the decrease in cardiac reserve is the major effect of presbycardia. What is the evidence to support the presence of decrease cardiac reserve? Immediately, we are faced with a problem difficult to solve because "there is no way to estimate myocardial efficiency without overloading the heart and determining when dilatation and prolongation of systole begin."² Much suggestive evidence presents itself, as (a) the sinus rhythm is somewhat less labile and compensates more slowly to postural changes;¹⁷ (b) also, "Whatever the nature of this aging change, it is obviously associated with a slow recovery from contraction and is brought to light by rapid heart action of whatever cause,"² and (c) Brandfonbrener, Landown, and Shock¹⁸ concluded from dye studies that there is a small, but definite and progressive decrement in cardiac output with age in subjects without clinical evidence of cardiovascular disease. All these changes of functional capacity may be secondary to a "disease phenomena associated with decreased total metabolism of the individual rather than a specific pathologic process."¹⁷ Perhaps the recent work of Kohn¹⁶ is the first strictly objective approach to the problem of the true etiology of this decreased cardiac reserve which is apparent. A short discussion of this work is in order. Seeking an underlying, age related change of cardiac muscle which would appreciably decrease cardiac reserve they turned their attention to the osmotic swelling properties of human collagen with respect to age. They obtained 148 hearts from

postmortem examinations and studied the swelling ability of the muscles of these hearts. (Each sample of myocardium was cut into three 25-40 mgm. fragments, washed briefly in 0.9 per cent NaCl, blotted firmly dry, and weighed. The fragments were then placed in 10 ml. of distilled water adjusted to required pH levels by addition of NaOH or HCl where they were maintained at room temperature for varying time. After removal, the fragments were again blotted and weighed. Per cent change in weight during incubation was then calculated, and used as a measure of swelling.) They found that young specimens can show swelling more readily than old. The extent of swelling remains at a constant level between the ages of eight and 35 after which there is a decrease. The factors involved seem to be related to the character of the protein elasticity. It is significant that they were able to show a relationship between the loss of swelling of myocardial proteins and decreased ability of the heart to contract efficiently. This seems to be due to loss of protein elasticity. Work supporting these findings remains to be done.

Decrease of Cardiac Reserve

Other extra cardiac sources of decrease of cardiac reserve must be considered. One such consideration is that by Shock, who demonstrated that "in persons 70-80 years of age who are clinically free from cardiovascular renal disease" a decided renal function decrease is noted.¹⁹ It is conceivable that this is a factor in the greater susceptibility of aged persons to the development of heart failure.

In consideration of the many minor changes in ECG concomitant with age, one must conclude that an ECG in an elderly person which differs from the normal pattern of adults should be considered to indicate a pathological condition and to be no manifestation of the natural process of aging. It is said there are no "characteristic disturbances of cardiac mechanism or other irregularities of the heart in older patients."¹⁷ Some changes which are significant in the young adult are not so considered in the aged. These changes are due to a number of conditions: (a) some mere anatomic alterations with age; (b) others due to subtle pathological changes, and (c) still others due to unknown causes.

A. Examples of the changes in ECG related to anatomic changes are: *left axis deviation* secondary to cardiac displacement by scoliosis from degenerated intervertebral discs, to a high diaphragm from obesity or disuse, or to filtering upwards by a relatively fixed unfolded aorta;²² *decreased voltage* (only approximately five per cent²¹ due to "senile emphysema.")

B. Examples of changes due to subtle pathological

changes are the disturbances in rhythm and left axis deviation (secondary to left parietal block) both secondary to cardiac sclerosis or coronary sclerosis.

C. Examples of changes due to unknown causes are extra systoles which "may be produced by fatigue or toxemia from over smoking or alcohol."²²

How is the diagnosis of presbycardia made? "The diagnosis rests on: (1) the fact that readily recognizable changes of senescence are present in the body and (2) absence of convincing evidence of the presence and significance of other forms of heart disease,"²³ particularly coronary atherosclerosis (absence of EKG evidence of coronary disease and history of angina pectoris).

Isolated Presbycardia Rare

Isolated presbycardia is probably extremely rare. The presence of presbycardia as a factor greatly affecting the ability of the heart to compensate for structural compromise of efficiency is probably the more important application of the concept.

Treatment of presbycardia in its pure form (manifested by congestive heart failure) is the same as the treatment of congestive heart failure due to other causes, but the response is much more gratifying. Blumgart feels the treatment for arrhythmias due to presbycardia (an unacceptable view) is the same as that for arrhythmias on a coronary sclerotic basis²³ when the condition is undoubtedly present, but asymptomatic, no treatment is indicated. In the treatment of congestive heart failure due to some obvious pathological condition (which is to a great degree affected by presbycardia), the treatment is not affected by the presence of the presbycardia.

Conclusions

In conclusion, I must say that presbycardia is an extremely important concept for three reasons: (1) it prevents the non-scientific diagnosis of unexplained congestive heart failure; (2) it keeps us ever aware that a disease process acting in time is affecting an organism (or organ) which is also altered by the time factor, and (3) it keeps us always alerted to the possibility of subtle pathological processes which are only rendered clinically evident by the complicating factor of age.

I fear that the proper perspective of this process specifically and the aging process, in general, is awaiting biochemical explanation.

As A. J. Carlson²⁴ has said, "We are not yet in a position to determine with the certainty of science to what degree the changes in the machinery of the body, which parallel advancing age, are due to genetic constitution of the individual and the species, that is, to the aging process *per se*, and how much

is due to the accidents of life, such as faulty diet, infection, overwork, laziness, or gluttony.”²⁴

Medical College of Georgia

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SABIN LIVE-VIRUS POLIOMYELITIS VACCINE

REPRESENTATIVES OF THE MEDICAL and health professions, the federal government, and national civic groups are cooperating in development of a program for starting the general use of the Sabin live-virus poliomyelitis vaccine next year.

Shortly after clearing the Sabin vaccine for general use, Leroy E. Burney, M.D., Surgeon General of the Public Health Service, asked 23 non-government organizations to designate members to serve on a Surgeon General's Committee on Poliomyelitis Control.

An Agenda Committee met with PHS officials in Atlanta Oct. 11 and 12 and drafted a basic agenda for a meeting of the Control committee in mid-winter. At the Atlanta meeting, preliminary consideration also was given to administrative and technical problems involved in use of the live-virus vaccine developed by Albert B. Sabin, M.D., of Cincinnati.

The Agenda committee was made up of representatives of the American Medical Association, American Academy of General Practice, American Academy of Pediatrics, Association of State and Territorial Health Officers, Children's Bureau, and the National Foundation.

The Sabin vaccine is not expected to be available in substantial quantities before mid-1961.

The chief question is whether the vaccine—which is given orally in the form of pills, liquid or candy—will be administered on individual or mass community basis.

The PHS special committee that recommended approval of the oral vaccine said that the community basis would be better.

“Because of the unique nature of live poliovirus vaccine, with its capacity to spread the virus in a limited manner to non-vaccinated persons, the committee cannot make recommendations for manufacture without expressing concern about the manner in which it may be used,” the special committee said.

“The seriousness of this responsibility can be illustrated, for example, by the known potentiality of reversion to virulence of live poliovirus vaccine strains, and the possible importance of this feature in the community if the vaccine is improperly used.

“For example, the vaccine has been employed largely in mass administration where most of the susceptibles were simultaneously given the vaccine, thus permitting little opportunity for serial human transmission; or, it has been administered during a season of the year when wild strains have usually shown limited capacity for spread. This experience should provide the basis for developing useable practices for the U.S.A.”

The special committee also said attention should be given to administration to special groups, such as very young children, pregnant women, and susceptible adults.

“Even more important is the planned continuation of this program as long as necessary to achieve and maintain the required results,” the committee said.

PSYCHOPHYSIOLOGICAL FACTORS IN JUVENILE DELINQUENCY

Harry R. Lipton, M.D., *Atlanta*

The delinquency rate in middle class areas and suburbs is equalling, and in many cases, surpassing that in the slum areas.

AS LATE AS 150 years ago, children seven years of age were hung for offenses such as stealing. During past generations, violent crimes committed by children were almost unknown. Today, we have as many as three murders a week committed by teen-agers in one large city alone. There is a definite trend toward more violent types of misbehavior, such as murder, mayhem, felonious assault, and rape. Although statistics are not readily available, it is the opinion of this physician that, because of the great mental and emotional tension and turmoil in our adolescents, we now have, in addition to an increase in delinquency, more psychopathic behavior and more mental illness. Indeed, suicidal attempts are not uncommon among juveniles and seem to be on the increase; this is only a manifestation of the great aggression and hostility which, in the presence of emotional depression, are turned back upon the self. Prostitution, venereal disease, drug addiction, and drinking are increasing alarmingly among our teen-agers. Last year a half million juveniles were in court, twice as many as ten years ago.

Three out of every 100 youngsters will be hauled into Juvenile Court this year. A senate subcommittee estimates that more than one million youths between ten and 17 will be brought before the courts in 1965 if the present upward trend in juvenile delinquency continues. Indeed, figures from all over this country indicate that the rate of juvenile delinquency is increasing four times as fast as the juvenile population is increasing.

We wonder as to the cause of this explosive increase in the incidence of juvenile delinquency. We

have, as a society, over-reacted to the severe corporal punishment of past generations and gone to the extreme of too little control, and little or no punishment. Actually, there has been a collapse of authority, with teen-agers running wild. In many households there is no head. In many others, the father is an assistant mother, cook, and laundress.

Increased Employment of Women

With the increasing employment of women during the past several generations, many wives now earn more than their husbands and make the financial and other decisions in the family. Also, in most American homes, decisions concerning the children are made jointly by both parents. This is probably as it should be. The teen-ager, however, uses one parent against the other; he gets from mother what he cannot get from father, and vice-versa. For several generations, freedom of expression for our children and youth has been the vogue; this regardless of what the child or youth has to express. It has been theorized that thwarting the child will result in neurosis. Our present generation has not been thwarted like past generations, yet is probably as neurotic as any generation in the past.

Shameful, inadequate, and tragic home environments still play a great role in juvenile delinquency. The collapse of so many of our homes is an important factor in our high rate of juvenile delinquency. A southern state training school, which handles about 90 girls per year ranging from 11 to 19, has in it 12 girls with records of incest. In the opinion of this physician there are, no doubt, 12 or more other girls in this training school who have also been the victims of incest, but who are too terrified to divulge this to anyone.

Teen-agers seem to be running more in gangs

and gang membership is frequently used as a shield for aggressive, anti-social behavior. The adolescent feels that, because the others in the gang are doing the same thing, he should therefore not be severely punished. The environmental and situational circumstances prevalent in the gang result in aggressive anti-social acts, many of which would not otherwise occur.

Many Antiquated Laws

Also, there are a number of antiquated laws, such as making it a misdemeanor to provide cigarettes to persons under 21; statutes making it a misdemeanor for a minor to roll ten-pins, and other similar statutes on the law books which are not enforced, which tend to create a disrespect for laws in general. Many communities have curfew laws which are undesirable and most difficult to enforce. We cannot expect the police to watch and care for our children and adolescents; this was, and still is, the parents' job.

Too Many Idle Hours

In past generations all children had their duties in the home, keeping up the lawns, carrying out ashes, washing dishes, waxing floors, etc. Nowadays, with dishwashers, gas furnaces, cooks, scrub-women, and yardmen, even the children of our middle-class homes have many unfilled hours after school. Also, we force our children to remain in school until they are 16, regardless of their desire to learn or their ability to learn. In many cases the result of this is idleness, disrespect for authority, and delinquency. We prolong our youth's dependence, whether he wants this or not. We do not allow him to leave childhood when he is ready to set forth himself, but establish arbitrary ages when he may leave school, go to work, etc. Suddenly and overnight he is expected and forced to cope with the opportunities, conflicts, and demands faced by adults.

Children 14 and over who do not desire to remain in regular school, or who cannot profit from regular school, should have the opportunity of going to trade schools or becoming apprentices in the various trades, as is the custom in European countries.

The youngster of today cannot run away from home and ship out to sea, join an Army, or easily find work, as in past generations. The terrific endocrine changes going on during youth and adolescence promote great physical activity. With these are strivings toward self-expression, self-assertiveness, and independence. With the old outlets gone the rebellious and adventurous youth of today is

more apt to find his outlet in aggressive anti-social behavior.

Many Hours Spent Watching TV

Our children spend hours on end watching television. We find not too many wholesome, cultural, and historical programs. In most of our television programs, murder, mayhem, and sex are dramatized and glorified. Although television cannot be blamed for our great increase in juvenile delinquency, so many of the programs are not the best food for idle minds and bodies. Also, the violence portrayed through our radio programs and motion pictures definitely tends to increase such behavior among adolescents.

We can easily understand how poverty, neglect, and deprivation can predispose to delinquency in slum areas. It is more difficult to understand the delinquency in the middle and upper class areas and in the suburbs. Indeed, we now have a large group of suburban delinquents and the delinquency rate in the middle-class areas and suburbs is equaling, and in many cases surpassing, that in the slum areas. We also have a large group of rural delinquents; here, no doubt, poverty and boredom are large contributing factors.

There is no doubt but that the anxiety of the elders in this atomic age has by contagion infected the youth and adolescent. We live in danger of annihilation by forces that we cannot see, hear, or smell, or anticipate in any other way, except possibly by warnings on our radios. The increased tensions of of this atomic age play an important role in the emotionally disturbed state of our youth. This is evident in this country and quite a few other countries throughout the world.

Behavior of Adolescent Is Complex

Much has been said about not understanding our adolescents. The behavior of the disturbed adolescent is most complex and not identical in any two. It is determined by his past experiences, the emotional shocks and insults he has suffered, his identifications, his relationship to his parents, and the circumstances and conditions under which he is presently living. Many of our adolescents obtain their feeling of recognition and achievement not through accomplishment in school or on the playground or athletic field, but through aggressive anti-social acts.

Our adolescents need more companionship, supervision, guidance, control, moral and religious training, and help in releasing their energies and drives in wholesome and constructive activities. Unless we help them in this way, we can expect a continued explosive increase in juvenile delinquency.

Moral and spiritual training is deficient in our schools. Our children and adolescents need this training seven days a week, not just in Sunday School. I do not mean to suggest that our schools should be church-directed; religious instruction should be mandatory and in accord with the church affiliation of the child. We need to set aside one to two hours a day for religious teaching in our schools, beginning in the early grades.

We are, all in all, doing too much for our children and our government is doing too much for us.

The child keeps running to his parent, his parent to the government, and one government to another government. As in ancient Rome, and other civilizations which have crumbled, we are looking to some central government or power to do more and more for us. We cannot maintain our democracy, the greatest any civilization has yet known, if we expect the government to do for us what we should do for ourselves.

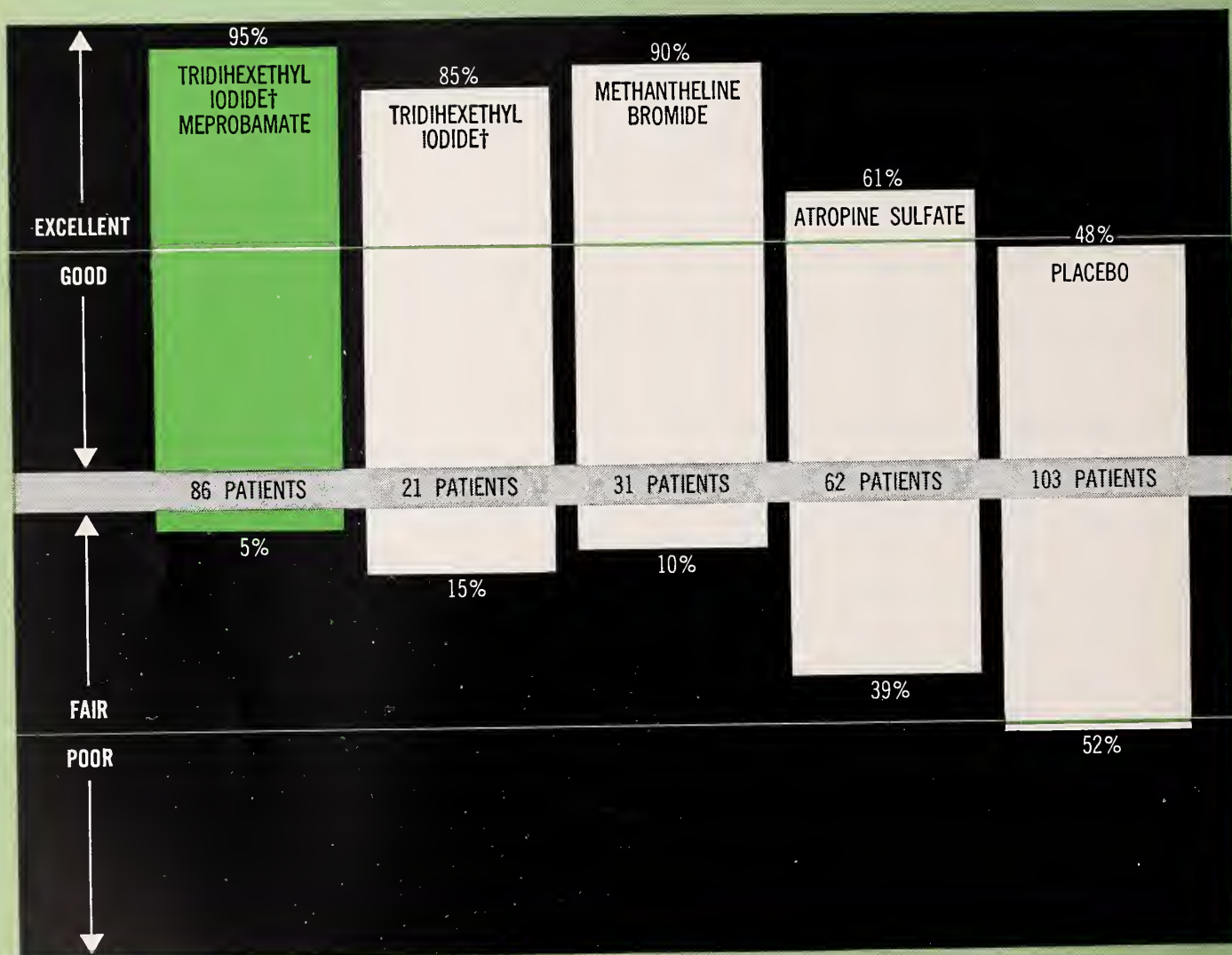
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STOMATITIS	1%	0%	28%	14%	0%
VISUAL DISTURBANCES	0%	0%	50%	34%	1%
URINARY RETENTION	0%	0%	18%	11%	1%
DROWSINESS	20%	0%	0%	0%	0%
COMPLICATIONS OR SURGERY					
HEMORRHAGE	0%	9%	3%	9%	10%
PERFORATION	0%	0%	0%	6%	0%
OPERATION	0%	5%	5%	14%	2%
RECURRENCES					
NONE	28%	23%	25%	17%	26%
FEWER AND Milder	67%	62%	52%	37%	24%
SAME OR MORE	5%	15%	23%	46%	50%

*Atwater, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. *Am. J. Digest. Dis.* 4:1055 (Dec.) 1959.

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ANIMAL DISEASES TRANSMISSIBLE TO MAN

The control and eradication of the various zoonoses has contributed to a healthier human and animal population.

James H. Steele, D.V.M., M.P.H., *Atlanta*

THE RECENT W.H.O. EXPERT Committee on zoonoses lists more than 100 animal diseases transmissible to man, in addition to a number of other infections common to both man and animals. Startling as this may be, nearly all of these diseases, with the exception of some newly-described viral infections, are long-standing zoonoses.

Rabies is most important among the viral diseases that affect both man and animals. Its public health importance is recognized in every health jurisdiction. The problem is measured by the number of persons, usually children, who must take antirabies treatment after being bitten by rabid animals. It is conservatively estimated that at least 600,000 persons require medical care annually as a result of animal bites.

Dogs Provide Biggest Rabies Threat

Some 30,000 or more of these persons are required to take antirabies treatment, either because they were bitten by known rabid animals or by a stray animal not available for examination. Dogs, as one would suspect, are the greatest offenders, followed by cats and wild canidae. The dog and cat populations are estimated to be more than 50,000,000 or approximately double that of 15 years ago. It is entirely possible this number will double in the next 15 years, when one realizes humane authorities estimate that 86,000,000 puppies and kittens were born in 1957. A large number of these animals do not survive, however, because of disease, accidents, and destruction. But it is important that those taken into households be immunized against rabies, lest they become vectors of the disease, if they are exposed.

The Georgia dog population is estimated to be

more than 400,000, of which almost one-third is found in the metropolitan area of Atlanta. Last year, less than one half of these animals were vaccinated, even though the local health departments, with the support of the State Health Department, made an intensive effort to see that every dog was immunized against rabies. About 12,000 dogs are picked up and euthanized annually in the Atlanta metropolitan area, but despite this, wild dog packs are seen occasionally in the area along the Chattahoochee River. These animals, as well as foxes and bats, harbor rabies virus.

Rabies is only one of a number of viral diseases of animals. Fortunately, however, few of these cause clinical disease in man. Among those recognized in the southern states are cat scratch fever, St. Louis, eastern and western viral encephalitis, Newcastle disease, and psittacosis. Pseudo-cowpox, lymphocytic choriomeningitis, and vesicular stomatitis are occasionally seen. This disease, vesicular stomatitis, is enzootic in south Georgia. The disease in man causes an influenza-like illness.

Q Fever

The most important rickettsial animal infection today is Q fever. No longer a rare disease seen only in certain areas, it is now commonplace. It has been identified in cattle in both Georgia and Florida. The infection is benign in animals and causes no signs or symptoms of disease, even though the placenta is teeming with *Coxiella burnetii*, the causal agent. In man it causes a pneumonitis of a varying degree. Controlling the disease is difficult because of its benign nature. The enormity of the task is compounded by the size of the susceptible animal population—more than 100,000,000 cattle including

From the Department of Health, Education and Welfare, Public Health Service, Bureau of State Services, Communicable Disease Center, Atlanta, Georgia.

about 20,000,000 milch cows; 30,000,000 sheep, and 1,000,000 goats in the U. S.

Brucellosis

The bacterial zoonoses are quite numerous, ranging from anthrax to tuberculosis. The most important of this group in the United States is brucellosis. Fortunately, its prevalence in most parts of the country has been reduced through the work of the national brucellosis eradication campaign. Georgia veterinarians, agriculture officials, and dairy farmers are to be congratulated for bringing bovine brucellosis under control. The eradication of this malady is now possible, but it will require the continued efforts of everyone concerned. The most important aspect of brucellosis in 1960, to the physician, is the fairly high rate of occupational disease among hog butchers and processors of pork. The annual hog population of our country exceeds 100,000,000; 1.5 per cent (1,500,000) of which is estimated to be infected with brucellosis. Not only is porcine brucellosis a threat to human health, but it also can undo the control work already completed in cattle. During 1959 all of the human brucellosis cases proven by bacterial isolation and reported in Georgia were of the porcine type.

Staphylococcal and Streptococcal Diseases

The problems associated with streptococcus and staphylococcus infections in animals are many. Some animal health authorities believe that streptococcal and staphylococcal organisms cause more disease than any other microbes. A recent review places the economic loss at \$250,000,000 annually. These agents can be of concern to public health officials, especially if the animal infection is a human-type organism, e.g., group A streptococcus or certain antibiotic resistant staphylococci. Most of the animal streptococcal infections are of the B group and occasionally C, D, and E groups. Some of the same kinds of staphylococcus phage types are found in both man and animals. Some staphylococci are toxin producers. These are a common cause of food poisoning.

Salmonella Infections

Salmonella infections are a major disease problem among domestic animals and fowl. More than 500 species of Salmonella have been found in animals, many of which may cause disease in man. Animal feeds are frequently found to carry these bacteria as contaminants. Animals, including fowl, that ingest contaminated feed may become infected and serve as carriers or a source of infection for man. Surveys in the South have revealed that animal food products often are contaminated. Sometimes the source of contamination is human carriers.

Fungal Diseases

Animal fungal diseases have assumed considerable public health significance in many parts of the country. A recent study by the Communicable Disease Center reveals that animal ringworm is a problem wherever there is a cat and dog population of any size, and frequently spreads to adults and children. In fact *Microsporum canis* is believed responsible for 20 per cent of the human ringworm in this country. *M. audouini* formerly identified only with infections in man is now being found in animal pets. Recently, there was an outbreak of this disease in a children's zoo which affected many animals.

Ringworm of cattle due to *Trichophyton verrucosum* is not uncommon among cattle in the southern states. The organism grows as a saprophyte and persist for years on some farms. Occasionally, farm families contract the disease, as well as other persons in close contact with diseased animals.

Histoplasmosis, coccidioidomycosis, and blastomycosis have not yet been reported in domestic animals in Georgia. In areas where these diseases occur, animal infections are quite common, but fortunately animals are not primary reservoirs of infection for man, with the possible exception of dog in advanced stages of coccidioidomycosis.

Aspergillosis, a common disease of birds, is periodically encountered as a cause of illness in man. Although moniliasis is occasionally seen in animals, it is doubtful that they serve a reservoir for man. Actinomycosis and sarcosporidiosis, both long-standing infections of animals, are seldom diagnosed in man today in the United States.

Parasitic Problems

The most important zoonoses in many areas of the world are the parasitic infections of animals affecting man. These include protozoal infections, of which toxoplasmosis is an interesting example. Most medical investigators think that animals, especially cats and rodents, are the reservoir of *Toxoplasma gondii*. Occasionally other animal protozoa, such as coccidia and *Balantidium coli*, also produce disease in man.

The fluke parasites are of little importance to U. S. public health—exceptions are those agents causing swimmers' itch among bathers. This infection in man results from the reaction of an aberrant host to a parasite of birds and rodents. It is common in the northern states and is being diagnosed more frequently in the southeast.

Among the oldest zoonoses problems is taeniasis. The ancient Egyptians and Jews recognized it as a health problem. The first modern meat inspection laws were based on eliminating tapeworm cysts as

ANIMAL DISEASES / Steele

a human health hazard. The most important of these are the beef (*Taenia saginata*), and pork (*Cysticercus cellulosae*) tapeworms. Occasionally, beef tapeworms encountered in migratory farm workers, while pork tapeworm is exceedingly rare in either man or swine in this country. Meat inspection serves as the first line of defense against these worms. Among other animals harboring tapeworms are the dog (*Dipylidium caninum* and *Echinococcus granulosus*), rat (*Hymenolepis nana*), and fish (*Diphyllbothrium latum*), but most of these are rare in man in the U. S. Fish tapeworms are sometimes found among persons who like raw or partially cooked fish.

Recently a few cases of human hydatid disease (*Echinococcus granulosus*) have been reported in in some southern and western states. This is one of the world's major zoonoses, and every effort should be made to eradicate it. The dog is the primary reservoir for man and domestic animals.

Human Trichinosis

Despite the fact that the rate of human trichinosis infection has declined with the enforcement of local and state garbage cooking laws which forbid the feeding of raw garbage to swine, this disease probably still is one of the most widespread of the nematode infections of man and animals. Recent surveys of swine reveal that the infection rate is less than one per cent. Diseased swine usually are found to have access to raw garbage or other diseased animals. Trichinosis has a wide reservoir among wild flesh-eating animals and rodents.

Larva Migrans

Cutaneous larva migrans is widespread in the southeastern states, especially in the sandy soil areas where the larvae of the dog and cat tapeworms, *Ancylostoma caninum* and *A. braziliense*, are found. The infectious larvae penetrate the skin of humans who come in contact with them in moist sandy soil where they are viable. In man the larvae wander about aimlessly beneath the skin causing severe pruritus.

Fortunately, man is resistant to further penetration and the larvae do not reach the blood stream.

Prevention of the infection in man is difficult in areas where there is a large reservoir of diseased dogs and cats. Dog and cat control is essential. Larvicides are valuable in destroying the infectious larvae on play grounds, beaches, and sand boxes, and contaminated areas in back yards and under houses. The treatment of pet animals is important in preventing household infections.

Two other animal parasites causing trouble in man are dog and cat roundworms, *Toxocara canis* and *T. cati*. Children become infected by ingesting soil containing the ova, which are excreted by diseased dogs and cats. The ova hatch in the intestine and then migrate into the lymph vessels, which carry them to various organs where they begin their blind migration, causing reactions of varying intensity and severity. Prevention again is based on dog and cat control. Contamination of the soil and environment by household pets can be avoided by periodic examination of the animals.

Control of the Zoonoses

The reporting of zoonoses in animals and man is essential to agencies which are concerned with animal and human health. When the incidence of disease is known, especially as to its effect upon man, plans can be laid for its control. This is especially true of diseases of small animals and pets that have close contact with man. The enormous increase in small household animals in recent years had emphasized their importance as possible reservoirs of disease. If these pet animals receive home supervision and preventive veterinary medical care, they are rarely a public health problem.

The control and eradication of the various zoonoses has contributed to a healthier human and animal population. Though great strides have been made, there is still much to be done—and even with the conquest of the old problems, there are many new ones waiting.

Communicable Disease Center

MAG Conference For

Presidents and Secretaries of County Medical Societies

Dinkler Plaza Hotel

December 10-11, 1960

Atlanta, Georgia

New Medical Program for the Needy Aged

Herman E. Talmadge, *U.S. Senator*

WHATEVER ITS SHORTCOMINGS, the Second Session of 86th Congress must be given credit for facing up to the pressing problem of providing medical care for the needy aged of the nation and effecting a realistic solution in keeping with historic American concepts of doctor-patient and federal-state relationships.

Congress came to grips with the issue during a politically-charged, post-convention meeting. The decisive vote was taken August 23 in the Senate which, when confronted with a clear-cut choice between compulsory health insurance and a voluntary program of federal-state assistance, chose the latter 51 to 44.

The bill as signed into law by the President was essentially that perfected by the Senate Committee on Finance and approved by 12 of its 17 members. It was my privilege, as a member of that Committee, to have a part in the drafting of the final version of the measure, which I regard as a significant advance in responsible welfare legislation and believe will prove to be both effective and popular when fully implemented.

EDITOR'S NOTE: Senator Talmadge was invited to prepare the above article because of his prominent role as a member of the Senate Finance Committee in the drafting of new legislation for medical care of the needy aged.

Safeguards

As one who always has recognized society's obligation to provide for those who cannot provide for themselves, the question for me was not one of whether legislation on the subject should be enacted but rather of what safeguards it should contain to make certain that it would not later prove to be the opening wedge for socialized medicine in this country. In that regard, I determined that any program which I supported would have to meet the following criteria:

- (1) be voluntary
- (2) be limited to the needy aged
- (3) be a federal-state matching program under state control
- (4) be financed from general revenue rather than a payroll tax
- (5) preserve the right of the patient to choose his doctor and hospital
- (6) preserve the right of the doctor to determine his own practice.

It is a source of great satisfaction to me that the law which was passed embraced all of those fundamental points. That such was the case, despite election-year pressures to the contrary, is indicative of

SENATOR HERMAN E. TALMADGE is now serving his fourth year as United States Senator from Georgia. A native of McRae, he succeeded retiring Senator Walter F. George in 1957. Prior to this he served as Governor of Georgia from 1948 to 1955.

Of all his many accomplishments and distinctions, Senator Talmadge prefers to be known as a farmer. His roots in the soil of Georgia grow deep. He was born and reared on his father's farm in Telfair County near McRae. He now operates two farms of his own, one at Lovejoy where he resides, and another, the old family homestead at Forsyth, 35 miles away. Although still a young man, he has had an illustrious career as an attorney, farmer, insurance executive, public servant, Naval Officer, newspaper publisher, author, and television personality. When not in Washington, Senator and Mrs. Talmadge and their two sons reside at "Talmadge Farms," Lovejoy, Henry County, 26 miles south of Atlanta.



Herman E. Talmadge
U. S. Senator, Lovejoy, Ga.

NEW MEDICAL PROGRAM / Talmadge

of the continuing vitality of the American principles of individual initiative, self-determination, and local self-government.

Two Phases

The new law takes a two-pronged approach to solving the problems of citizens 65 years-of-age and older who are in need of medical assistance. It amends Title I of the Social Security Act to provide, effective last October 1, for: (1) additional matching funds to the states to establish new or improve existing medical care programs for the 2.4 million persons presently receiving Old Age Assistance benefits and (2) federal grants to the states for payment of part or all of the medical services of an additional 10 million aged citizens who are not receiving Old Age Assistance benefits but who may, at one time or another, be unable to pay for medical and hospital care needed to preserve their health and prolong their lives.

The sum of both facets of the plan, thus, is to cover all medically-needy aged who have reached their 65th birthday regardless of whether they are eligible for Old Age Assistance or whether they are receiving benefits under the Social Security or other retirement programs. In both cases the participating states will have broad latitude in determining both the eligibility of participants and the scope of benefits so long as their plans are approved by the Secretary of Health, Education and Welfare as complying with the requirements of the federal law.

Matching Formula

States already had authority to give medical aid to recipients of Old Age Assistance in the form of both money payments to the individual and vendor payments to doctors and institutions providing specified medical services. The maximum federal-state funds available for all phases of Old Age Assistance, including medical services, prior to the enactment of the new law, was \$65 per month for each person on the assistance rolls. The actual amount received from the federal government by each state was determined by the State's per capita income and the degree of its own participation in the program; Georgia, for example, receiving 65 per cent of its Old Age Assistance budget.

The new statute authorizes the federal government to match state funds used exclusively for vendor payments for medical services up to a combined total of \$12 per month over and above the previous \$65 monthly maximum. That, of course, is only a basis for computing the amount of the maximum federal Old Age Assistance grant to a state and does not mean, as some have contended, that a state

would be limited to \$12 a month in the amount it could spend for medical care in any individual case.

States participating to the maximum extent in the program may now budget as much as \$77 for each person on their old-age assistance rolls compared to the previous \$65. The amounts those states will have to put up to qualify for the new maximum will depend upon their per capita incomes.

States participating to less than the maximum extent in the program will receive each month from the Federal Government amounts ranging from 65 to 80 per cent of the sums they program for vendor medical assistance, the actual figures depending upon per capita incomes. In Georgia's case, the amount will be 80 cents of every dollar budgeted for that purpose.

This approach was devised as the best means of encouraging the States to extend comprehensive medical services to all needy persons receiving monthly assistance payments. It is estimated that its cost for the first year will be \$142 million to the Federal Government and \$4 million to the States and its eventual federal costs are expected to run to \$175 million annually.

New Program

To qualify for participation in the new program for Medical Assistance for the Aged, there are certain requirements with which a state must comply. It will have to submit plans which will apply equally to all medically-needy aged 65 and over and which must include "reasonable standards, consistent with the objectives of this title, for determining eligibility."

On those points, the Senate Finance Committee stated in its report:

"Under this program, it will be possible for States to provide medical services to individuals on the basis of an eligibility requirement that is more liberal than that in effect for the States' old-age assistance programs . . . A state may, if it wishes, disregard in whole or part, the existence of any income or resources, of an individual for medical assistance. An individual who applies for medical assistance may be deemed eligible by the State notwithstanding the fact he has a child who may be financially able to pay all or part of his care, or that he owns or has an equity in a homestead, or that he has some life insurance with a cash value, or that he is receiving an old-age insurance benefit, annuity, or retirement benefit. The State has wide latitude to establish the standard of need for medical assistance so long as it is a reasonable standard consistent with the objectives of the title . . . The Committee intends that States should set reasonable outer limits on the resources an individual may hold and still be found eligible for medical services." (Senate Report 1856, 86th Congress, 2nd Session, pages 6-7).

The Act specifically prohibits the requirement of

a premium or enrollment fee, the imposition of a citizenship requirement which would exclude a citizen of either the United States or the State concerned and the imposition of property liens during the lifetimes of the individual receiving assistance or his surviving spouse.

State Sets Scope

A state's plan for medical assistance in this category may specify both the scope and duration of the medical services for which assistance is to be given, provided that both institutional and non-institutional services are included. The law states that the Federal Government will share in the costs of any or all of the following kinds of medical services:

- (1) in-patient hospital services
- (2) skilled nursing home services
- (3) physicians' services
- (4) out-patient hospital or clinic services
- (5) home health care services
- (6) private duty nursing services
- (7) physical therapy and related services
- (8) dental services
- (9) laboratory and x-ray services
- (10) prescribed drugs, eyeglasses, dentures, and prosthetic services
- (11) diagnostic, screening, and preventive services
- (12) any other medical or remedial care recognized by state law.

(One shortcoming of the law as passed is that it does not permit federal contributions toward medical services furnished for inmates in non-medical public institutions or to patients in mental or tuberculosis hospitals. The Senate approved an amendment which would have made funds available for those purposes but it was eliminated by the Conference Committee which compromised conflicts between the House and Senate versions. There was included, however, a provision for federal matching of costs for the first 42 days of care to a patient in a medical institution other than a tuberculosis or mental hospital as the result of a diagnosis of tuberculosis or psychosis.)

While the specific details will depend upon the procedures adopted by the individual state, the general way in which the program would work is that the aged person in need of medical treatment or hospital care which he could not afford would apply to the designated state or local agency for assistance in obtaining it. Upon determination that the individual's case fell within the authority of state law, the agency would approve the needed services and make the required payments directly to the aided person's doctor or hospital.

The law would not, as has been charged, require

a recipient of benefits to be indigent. All that would be necessary would be a determination, in accordance with the criteria adopted by the state concerned, that the applicant was in need of medical assistance which he was unable to provide for himself.

The Federal Government's share of the cost of this new medical assistance program will be determined by a formula similar to that used in computing the federal part of Old Age Assistance payments under \$65. The formula is based upon per capita income related to the national average with upper and lower limits of 80 to 50 per cent of the total costs. Georgia can expect to receive thereunder 74.36 per cent of the amount it budgets for this purpose.

Cost of New Program

It is estimated that the first-year costs of this phase of the program will amount to \$60 million in federal funds and \$56 million in state funds with the eventual federal cost placed at \$165 million.

In both phases, the Federal Government will share administrative expenses with the state governments on a dollar-for-dollar basis.

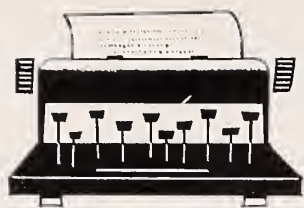
Those states which were providing medical care for the aged as part of their welfare programs prior to the enactment of this legislation already are benefiting from it to the extent that they had available matching funds. Other states must await the enactment of necessary implementing legislation and appropriations by their legislatures.

Georgia's Participation

Governor Vandiver has appointed a study committee to make recommendations to him and to the General Assembly as to Georgia's participation in this new program. The committee is composed of representatives of hospital, medical, dental, and pharmaceutical groups as well as representatives of the General Assembly and the departments of the state government involved.

It is to be hoped that the General Assembly of Georgia will act early in its forthcoming session next year to bring Georgia into maximum participation in both phases of the program at the earliest possible time. The doctors of Georgia can render a great public service both in urging such action and in giving Assembly members the benefit of their advice and recommendations as to how the program should be constituted and implementing legislation drafted so as to assure maximum benefit from it for all of Georgia's aged citizens.

Senate Office Building, Washington 25, D. C.



editorials

Tuberculosis Detection vs Tuberculosis Case Finding

WITH THE STEADY and continuing decline in tuberculosis mortality and the early, but promising, decline in tuberculosis morbidity, it is now possible to look forward with real optimism to the virtual eradication of tuberculosis from large areas of the world, particularly from the North American continent. It would appear that the achievement of this goal could be considerably accelerated, if the public were really aware of the great danger which lurks in the false sense of confidence that the tuberculosis problem has been conquered. In fact, although progress toward the eradication of tuberculosis seems favorable at this time, failure to accomplish this feat may well create an endemic pattern of drug resistant tuberculosis. On the other hand, if the present declining morbidity can be maintained, virtual eradication can surely be accomplished within the foreseeable future.

The importance of adequate treatment in bringing about today's favorable position with regard to the possibility of the eradication was pointed up by the recent Arden House Conference,* which reviewed the current status of tuberculosis control. Unfortunately, relatively few cases come to treatment during the minimal stage. Most are moderately advanced or far advanced. How, then, is it possible for a situation, such as this, to continue in the face of an obviously declining prevalence of tuberculosis? The answer probably lies in the fact that our case finding methods are not, in general, adequate to dis-

cover cases in their earliest stages. One of the chief reasons for this may be the fact that the x-ray of the chest has been the chief method employed in tuberculosis case finding surveys, hitherto. It is obviously impractical, except in certain circumstances, to have chest films taken every three months, year in and year out. But this is probably what would be required on an enormous scale, if one were to significantly increase the proportion of new cases found to be minimal at time of discovery. Consequently, x-ray survey programs leave a great deal to be desired, insofar as the early discovery of new active cases may be concerned.

How, then, can the problem of earlier detection of newly active cases be approached more effectively? Part of the answer to this question may lie in the wider use of the tuberculin test. Several things point to the advisability of our thinking in terms of tuberculosis detection, which implies merely the presence of infection and not necessarily the presence of active disease. The tuberculin test will indicate such infected individuals, since those who are positive have been infected at some time or other, and those who do not react have never been infected. Unfortunately, the tuberculin test does not reflect the activity of tuberculous disease, even when present. It is necessary to utilize x-ray examination and clinical findings to determine whether a tuberculin positive individual also harbors tuberculous disease, either active or inactive.

If we now concentrate our attention upon the tuberculin positive population, as delineated by tuberculin testing surveys, we can see from the

*A conference of national leaders in TB control held recently at Arden House, Harriman, N. Y., under auspices of U. S. Public Health Service and National Tuberculosis Association.

Arden House Report that some 75 per cent of new active cases emerge from the roughly 20 per cent of the general population which is tuberculin positive. This means that most of the new active cases are cropping up in individuals who are known, by virtue of their positive tuberculin reaction, to have been previously infected at some time, and that very few of the new active cases are cropping up in individuals who have been known previously to be tuberculin negative and, hence, uninfected. For this reason, it is being generally proposed that registers of tuberculin positive individuals be kept and that these individuals be x-rayed annually in order to detect new active cases as early as possible. This would concentrate the case finding function of chest x-rays upon the group which yields the largest number of new cases. Detection would thus be accomplished by the tuberculin test and cases of disease would be found by x-ray.

Such detection programs are well suited to certain relatively fixed populations, such as industries, schools, and charitable and penal institutions, whereas routine chest films are better suited to the survey of rapidly changing populations, such as general hospitals, out-patient clinics, and the like. Also, one of the most important applications of tuberculosis detection programs will be in the identification of tuberculin reactors among pre-school children. An intensive contact study is mandatory in all such positive cases and should usually reveal the source case in the child's background, as well as other tuberculin positive associates. Since such disseminators of tuberculosis are often unaware of their infectious status, a doubly valuable service may be accomplished.

It has already been well demonstrated that drug treatment of the child with asymptomatic primary tuberculosis virtually abolishes the occurrence of

later complications, such as military or meningeal involvement. It remains to be seen whether treatment of the tuberculin reactor, who has no clinical or x-ray evidence of disease, will significantly further diminish tuberculosis morbidity. Studies on this point are now in progress and the answer should be forthcoming in a few years, but, in the meantime, this is an added reason for detecting, registering, and observing the tuberculin positive population.

In summary then, we find the concept of case finding by x-ray surveys to be no longer adequate to the needs of tuberculosis control programs. If tuberculosis control programs are to be reoriented into tuberculosis eradication programs, we need to think in terms of tuberculosis detection by means of the tuberculin test and of tuberculosis case finding by means of x-ray observation of the tuberculin positive population. A combination of these two methods applied with new vigor, particularly among the older age group and the pre-school children, should lead to a higher yield of active disseminators of tuberculosis. The identification, isolation, and treatment of these disseminators will accelerate progress toward the ultimate eradication of tuberculosis. In addition, however, tuberculosis detection by means of the wider use of tuberculin testing will identify that infected portion of the population, still without evidence of active disease, which may yet prove suitable for prophylactic chemotherapy. Thus, although the role of the tuberculin test is clearly in tuberculosis detection and the role of the x-ray is now chiefly one of case finding among infected individuals, both methods of examination are essential, if we are to progress as rapidly as possible toward the ultimate goal of eradication of tuberculosis.

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Training for General Practice

THE PREVAILING ATTITUDE in academic medicine often seems to be that there is no place in the practice of medicine for the general practitioner. It seems worthwhile to examine this attitude more closely, since many graduates of medical school still enter general practice. For example, 40 per cent of

the class of 1953 of the Medical College of Georgia are now in general practice.

Why do so many competent and intelligent teachers of medicine feel that general practice is an anachronism? For one thing, the strict compartmentalization of medicine in medical college hospitals

gives rise to a loss of contact with other specialties and subspecialties, quite naturally producing feelings of inadequacy in all fields other than one's own. These feelings are mutually encouraged. More important, however, I think that judgment is often based on a comparison of *well-trained* specialists and *untrained* generalists.

The attitude of the specialist professor, as regards training general practitioners, is generally very negativistic. He thinks it is really a hopeless task—even a genius could not cope with learning all the ramifications of *his* specialty, *plus* other specialties. The very thought is preposterous. Equally preposterous seems the idea of accepting less than board certification as being adequate training for anybody. This all or nothing approach to training seems unreasonable. Would a "partly trained" generalist be more likely to "get in over his head" than an untrained one? I think not. I think that the more exposure a man has had to a specialty in his training period, the higher will be his referral rate in that specialty. He will have been alerted to diagnostic and therapeutic dilemmas at the same time that he has been instructed in the proper performance of his routine duties in that field. Incidentally, the naivete exhibited by specialty residents in areas outside their field would often appall even the untrained general practitioner.

Numerous writers have pointed out the advantages for the patient (and physician) of having a "family physician." These are quite real and do not require discussion here. The prevailing tendency at teaching centers would seem to substitute the "clinic" or "group" of specialists for the family physician. The patient can get total care for such a group, and it will be first-class care, although obviously much less personal. Also against the group system are its very high fees, time-consuming cross referrals, difficulties in administration (doctors are likely to be most individualistic and difficult to work with), and unavailability to small communities. Another point of view would have the internist become the family physician of the future. This is fine, but I can't imagine how a good family physician could fail to do pediatrics, minor surgery, gynecology, and probably obstetrics. The internist has been trained in none of these fields.

Many people think that doctors who go into general practice don't *want* training. They *can't get* training. Exceedingly few people feel adequately trained to practice medicine by the time they finish their internship. If a *good* training program in gen-

eral practice were offered at a teaching hospital, I am convinced that it would be snapped up. General practice residencies, as offered at many hospitals, are merely poorly disguised efforts to get the "scut-work" done cheaply. A successful training program for family physicians would have to offer several things to be outstandingly successful. They are:

(1) Sincere desire on the part of each department head to train family physicians and the real conviction that this is a useful function. It must be realized that the family physician should be a well-trained, capable doctor, and not someone with about the status of an industrial nurse to operate a cut-rate referral service and first-aid station.

(2) A numerically large enough group of general practice residents to carry some weight in hospital affairs, and preferable a faculty spokesman for the group. The resident should have an important function in the operation of the hospital and not be a "second class citizen."

(3) Pay status as befits his number of years postgraduate work.

(4) An integrated program by all of the major services. Three years including internship would seem to me to be a reasonable *minimum* program.

(5) Abandonment of the trade union state of mind—the kind that puts firemen on diesel locomotives, and forbids a carpenter to change a light bulb.

Benefits to Hospitals

Among the benefits that would accrue to the hospital offering such a program are:

(1) The closer integration of the various departments which now often seem like autonomous feudal kingdoms, continuously at war with one another. This could not help but improve patient care as well as improve education of students, house staff, and faculty.

(2) Increased stature for the remaining specialty residents. They would become true specialists, i.e., consultants, with broad responsibilities and opportunities in teaching. They would be freed from routine work with which they are bored. By increasing the number of residents on the lower levels of training, the necessity for the "pyramidal system" would be obviated.

(3) Reduction in the actual number of consultant specialists being trained each year. Surely the law of supply and demand should not be completely ignored.

If medical schools feel that they cannot, in good conscience, *train* family physicians, then surely good

conscience demands that they actively discourage graduates from going into general practice. Since the latter course is unrealistic and probably doomed to failure, a good training program for family physicians seems to me to be the only tenable choice. I

also think that it is essential for the continued improvement of medical care in Georgia.

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Let's Take a Good Long Look!

LET'S NOT JUST LOOK in a mirror. Better still, for objective vision, let's have our patients and the general public tell us about the image they see in our mirror. Then, let's learn together how we can polish some of the "cracks" they see—so that our reflection may truly represent our practice of medicine.

To take an unbiased look-see, the leaders of the profession in Georgia will be invited to attend the Medical Association of Georgia's Conference for County Society Officers, December 10-11, 1960 in Atlanta.

The theme of this session is "Improving the Image of Medicine." Plans for the meeting include a live telephone call survey of the patient's opinion of his doctor and a group discussion with a panel of leaders representing labor, business, the bar, and the press. These participants will give their views of Georgia medicine in a critical, but constructive, round-table presentation.

Another highlight of this program is data on a "brass tacks" approach to running a top-notch medical society. Scheduled for discussion on the program

are important medical society projects; tools of good administration; proper use of press, radio, and TV, and ways and means of getting the medical society work done. A special "bonus" for the society secretary is the presentation of a complete zipper loose-leaf notebook for use as a "walking office" to aid in fulfilling the duties of county society secretary.

The meeting is scheduled to begin Saturday afternoon at 2:00 P.M., December 10, so that each physician's wife may have ample opportunity to "Christmas shop" while her husband attends the session. A gala Social Hour for doctors and their wives is slated for early Saturday evening as a prelude to a night on the town in gay Atlanta. While Saturday's program will be held at the Dinkler Plaza Hotel, the Sunday morning program will be convened at the new MAG Headquarters Office Building to give everyone the opportunity to become familiar with MAG facilities.

For a better and more meaningful year of medicine in 1961, *all* county medical society officers are urged to follow this prescription: REPRESENT YOUR SOCIETY ON DECEMBER 10-11, 1960/ATLANTA!

A.M.E.F.—Our Responsibility

TWO STAIRWAYS LEAD to medical education. One leads to federally supported and controlled schools. The other leads to the door of our free and unfettered system of medical education—which has proven itself to be superior to any in the world today. Each

of these two stairways may be climbed, but to climb one requires some effort—the other, inactivity. It is up to each of us to see which stairway we use.

The cost of educating the future physician is high. So high, in fact, that the tuition he pays covers only

18.2 per cent of the actual cost of his training. Some of this deficit is made up by endowment income coupled with grants and bequests from individuals and foundations. But a gap remains. AMEF funds enable the school to keep valued faculty members, attract others, purchase necessary equipment at the time it is needed. In short, unrestricted money from AMEF provides a means of helping the medical schools face a grave problem without resorting to federal aid and its eventual control.

The American Medical Education Foundation is a tax exempt, non-profit corporation sponsored by the American Medical Association. Working through organized medicine, the Foundation solicits and distributes funds to the nation's 85 medical schools. These funds act as a supplement to limited operating budgets and help in keeping the schools free from the need of federal aid. The foundation is directed by 15 of America's outstanding physicians. Included are five past presidents of the AMA, the current president, and five who are now or who have been medical school deans. This board of interested and informed men form policy and regulate the activities of AMEF.

AMEF receives its money in three ways. First, from the activities of committees of physicians working through state and county medical societies to raise money in local AMEF campaigns. Another major source is the system of dues increases instituted in six states, whereby a portion of the state society dues are deducted and sent as a contribution to AMEF headquarters. Also active in behalf of AMEF are the women of the Auxiliary to the AMA, who have, as one of their major projects, the raising of funds for medical education.

Recognizing the serious financial plight of the nation's medical schools, the American Medical Association in 1951 started AMEF with a grant of \$500,000. It was thought then, as now, that medical education's problems were of significance to all segments of the population. A vigorous expression of concern by the medical profession would bring these problems into public view and enlist the aid of other groups in helping to solve them. To date,

physicians have contributed more than \$7,000,000 to medical schools through AMEF.

Distribution in the form of grants is made each year in February. At that time an equal distribution of all funds not designated for a particular school is made. Also sent to each school are those gifts earmarked for it by donors. Grants are made by AMEF without restriction and may be utilized by the dean in any way thought most beneficial. Because AMEF grants carry no restriction on their use, they find their way into many channels. Perhaps the most frequent use is that of providing adequate salaries to attract or retain qualified instructors and the purchase of needed equipment. Most of the letters of thanks received at AMEF headquarters stress the "emergency fund or pump priming" character of the grants. The grateful deans say that the money enables them to offer salary increments or purchase equipment at the time when it is actually needed. Otherwise, such action would have to wait until a new, (even larger) budget is approved.

Many contributors "earmark" gifts in favor of their Alma Mater. In addition, some contributors use their gifts to honor the name or memory of a friend or loved one. It is necessary only to note on the check or on a letter to AMEF headquarters the school you wish to designate as recipient. All promotional and office expenses are paid by the American Medical Association. Every dollar contributed goes to medical schools.

Aside from substantial support to the schools, the board of directors and state chairmen of AMEF are striving to achieve 100 per cent participation among physicians in this program to aid medical education. Only by such a unified approach can we stimulate other segments of the community to join in helping to solve the increasing financial problems of the medical schools. Each of us can help by joining with colleagues throughout the nation in making our gifts. Only by this voluntary method of giving can we assure continued freedom from federal control. It is this freedom from control which has been the dominant factor in making medical education in the United States acknowledged as the best in the world.

Write your check today and make it a generous one.

Invest in the future health of the nation and your profession

Give to medical education through AMEF

American Medical Education Foundation



535 N. Dearborn St.
Chicago 10, Ill.



heart page

THROMBO-EMBOLISM IN HEART DISEASE

Tully T. Blalock, M.D., F.A.C.P., *Atlanta*

WITH THE ACCEPTANCE and refinement of anticoagulant therapy it has become even more important to recognize and take steps to prevent thromboembolic phenomena wherever and whenever they may arise. The intern is taught early in his career to recognize the signs of vein inflammation and impending embolus. At the first hint of a positive Homan's sign, his thoughts shift to the anticoagulants and preventive measures. How often is this same anxiety directed to the patient with chronic heart disease, congestive failure, auricular fibrillation or rheumatic heart disease as a potential source of pulmonary or systemic infarction? Yet 20 per cent of patients dying of rheumatic heart disease and auricular fibrillation die from thrombo-embolism with the majority showing evidence of systemic emboli from cardiogenic thrombi. Over 10 per cent of deaths from coronary thrombosis occur as a direct result of pulmonary embolism with the incidence of pulmonary infarction exceeding 25 per cent in this same disease. Without anticoagulant treatment one third of all patients who have experienced a myocardial infarction will develop left ventricular mural thrombi. Nearly one half of these will at one time or another have cerebral emboli.

Thrombosis ranks as the outstanding cause of interference with the circulation through the coronary arteries, with coronary embolism occurring only

rarely. It is well recognized that acute myocardial infarction may occur in the absence of frank occlusion as a result of progressive coronary sclerosis with cardiac hypertrophy. The infarct in these latter cases is more frequently subendocardial rather than transmural as usually occurs with acute coronary occlusion.

Although the deep leg veins remain the primary source of pulmonary emboli, the frequency of mural cardiac thrombi and their importance in the production of pulmonary infarction and systemic emboli has only recently been more clearly recognized. Congestive heart failure is a frequent background for the development of pulmonary emboli. Auricular fibrillation, myocardial infarction or the occurrence of valvular vegetations may set the stage for disaster. The clinical picture of acute cor pulmonale with dyspnea, cyanosis, and severe chest pain may be followed by right heart failure with neck vein distention, enlarged liver, gallop rhythm, and death. The clinician should be alert for certain premonitory signs of impending trouble such as apprehension, anxiety, unexplained aggravation of the heart failure. Preventive steps may be taken before the major attack occurs. These warning signs supplemented by early electrocardiographic changes should call for vigorous prophylactic treatment. Development of an

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

S-wave in Lead I with depression of S-T segments in Leads I and II may be accompanied by Q-waves in Lead III and AVF or increase in the height of the P-waves.

Massive fatal pulmonary embolism may occur without pulmonary infarction with blockage of the main stem of the pulmonary artery by a large clot usually from the iliac or femoral vein. The simple dynamics of decreased left ventricular flow may produce shock and death.

Emboli arising from within the heart are usually small and may produce infarction in only 25-50 per cent of cases. These small emboli may cause symptoms such as cough, hemoptysis, chest pain, or even go unnoticed.

Systemic emboli may occur from thrombi within the left side of the heart. Soderstram noted that it was possible to distinguish two different types of mural thrombi within the left ventricle: (1) surface thrombi and (2) recessed thrombi, the latter being within the auricular appendage. Systemic emboli are a recognized hazard of rheumatic heart disease with auricular fibrillation and when noticed should be vigorously treated with anticoagulants. Such treatment may prevent propagation as well as formation of additional thrombi. Initial treatment should begin with heparin either intravenously or using the new

lipo-heparin subcutaneously. Heparin should be supplemented simultaneously with one of the coumarin derivatives with the latter being used exclusively, after the first 36 hours. Needless to say careful control of the prothrombin concentration is essential, however, the availability of Vitamin K1 has made the use of anticoagulants safer.

The majority of patients dying of mitral stenosis show the presence of systemic infarcts from left heart thrombosis. Recurrent cerebral embolism with destruction of the brain may complicate the long term course of the patient with heart disease. Non-fatal cerebral embolism constitutes an important cause of chronic organic brain disease.

Systemic emboli may be prevented by: (1) conversion of the rhythm to a sinus rhythm by the use of Quinidine®; (2) prolonged anticoagulant therapy; (3) left auricular appendage resection, and (4) mitral commissurotomy.

Anticoagulant therapy should be continued for 24 to 36 months even after mitral valve surgery.

In heart disease we are confronted with the problem of thrombo-embolism in both the role of cause and effect. The classic sequel of coronary artery thrombosis, infarction, and failure may in turn lead to intracardiac thrombosis, embolism, and death. Prevention in the form of control of failure, maintenance of normal rhythm, surgical repair of the valve, and judicious use of anticoagulants may avert disaster.

JOSEPH B. MERCER NEW PRESIDENT OF GAGP



Joseph B. Mercer, M.D.
Brunswick

DR. JOSEPH B. MERCER, general practitioner from Brunswick, is the new president of the Georgia Academy of General Practice.

Dr. Mercer, a past Director and Chairman of the Board of the Academy, was installed at the Academy's Twelfth Annual Meeting held in Atlanta at the Dinkler Plaza Hotel, October 12-13.

He succeeds Dr. Ben K. Looper of Canton as head of the organization. Named president-elect was Dr. Charles E. McArthur from Cordele, past vice president. Dr. W. Frank McKemie, Albany, was elected vice

president and Dr. M. F. Simons, Decatur, succeeds Dr. W. Mercer Moncrief, Atlanta, as secretary-treasurer.

Dr. Mercer, the new president, is a native of Jasper County, received his BS degree from the University of Georgia, his MD degree from the Medical College of Georgia, and interned at Columbus City Hospital.

He is past president of the Glynn County Medical Society and Eighth District Medical Society, MAG Delegate from Glynn County, Chief of the Department of Obstetrics and Gynecology at the Brunswick Hospital, a member of the First Baptist Church of Brunswick, and a member of Rotary International.

During the two-day meeting, many in-state and out-of-state physicians presented excellent papers and panel discussions, which highlighted the Twelfth Annual Meeting of the Georgia Academy of General Practice.



mental health page

PSYCHOTHERAPY WITH COUPLES AND FAMILIES

John Warkentin, M.D., *Atlanta*

PSYCHOTHERAPY, AS A PROFESSIONAL full-time effort on a major scale, developed in the course of World War II and immediately afterwards. Initially, psychotherapy had few distinct techniques of its own. It was recognized as separate from psychoanalysis because the psychotherapist less clearly directed the patient in the techniques to be followed in treatment, and saw the patient less often than the analyst. An almost simultaneous development was that of group psychotherapy. In fact, once the orthodox analytic approach was modified at all, many variations became possible. Psychotherapy became less clearly a medical undertaking, as pastors, psychologists, social workers, anthropologists, industrial counsellors, and many others made themselves available for various forms of the person-to-person relationship with a therapeutic intent. Since World War II, it has become almost impossible to circumscribe the field of psychotherapy, so many are its varied forms.

The individual patient is no longer the only object of concern in the psychotherapist's profession. There is a growing conviction that many patients are so closely intertwined with their families and other associates that it is not possible to treat them without including "psychological relatives" in the treatment effort.

Couples therapy and family therapy were natural variations to be undertaken, once the one-to-one relationship became less sacred. A new way of looking at the emotionally disturbed person emerged. Dr.

C. F. Midelfort in his book, "The Family in Psychotherapy" speaks of "A new theory which considers the family, not the individual, as the unit or organism in which illness occurs." He went beyond the question of treating the couple or family, to the further question of how relatives can directly assist in the psychotherapeutic treatment of a patient. Dr. David Mendell further emphasized the family as the "psychological organism" (my phrase) in his three-generation studies of illness in a given family. This kind of emphasis is also found in the books of Dr. Erika Chance, Dr. Nathan W. Ackerman, and Dr. Victor W. Eisenstein.

Treatment of married partners simultaneously in the same interview, or of an entire family, has become an increasing part of psychiatric work. The economic factor, that two or more people get treatment for the price of one, is not a major consideration. The patient with the symptoms may be expressing a sick orientation residing in a couple, or a larger family. As we have become more impressed with the significance of both healthy and sick dynamics in the life of a married couple or family, we have become more and more hesitant to pull out the one member who shows symptoms and treat that one alone.

When we first began treating couples as the patient-unit, we expected that treatment would take on a more superficial flavor, and be a matter of mere readjustment rather than reintegration for the patients. To our amazement, the opposite was some-

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

times the case. The more comfortable we as therapists became in sharing ourselves freely with a married couple, the more profound became the experience the three people in the room shared together. We found that we could now treat sicker patients, who could not have been treated alone in out-patient treatment.

One of the problems which have arisen in terms of theory, when a couple is treated as a unit, is that this presumably violates the concept of transference. In some respects this is probably true, and it is precisely because the transference conditions are violated that couples therapy increases the likelihood of existential encounters during the treatment hour. On occasion, it has seemed that the therapist could somehow be overwhelmed by the strong feelings evoked in couples therapy. Perhaps one reason for the greater courage necessary to treat a couple as a unit, or even a family, is that better treatment is now available for the therapist.* A further support in this rather difficult undertaking is available if the thera-

pist works with a group of colleagues. We often have a second therapist in for couples therapy, making it a four-way interview, either on a periodic basis or for all the treatment sessions with a given couple.

An example of couples therapy: A 27-year old woman with postpartum psychosis was actively threatening suicide; after three preliminary sessions in which this was discussed with her husband, she was clearly less suicidal, and a trial in out-patient psychotherapy was undertaken. The husband participated little, at time seemed resentful when sexual matters were discussed, but came regularly into the interviews with his wife while she steadily improved. In this case, and in most others, acting out was reduced to a minimum which we attributed to the presence of the spouse in the three-way interviews. A tremendous advantage of working with this couple as a unit was that we avoided a threat to marital togetherness, which sometimes results when only one of the partners undertakes psychotherapy.

** To be able to tolerate the stress of doing this kind of psychotherapy, it is very helpful for the therapist himself to have been a psychotherapeutic patient.*

DEPARTMENT ADVISORY COUNCIL HELPS DRAFT HEALTH POLICIES

OPERATING AN ORGANIZATION the size of the State Health Department is a big job. Making decisions which affect the policy of the Department is a task that needs the thinking and consideration of the various programs within the Department.

For this reason, a Departmental Advisory Council was established by the Director, Dr. John H. Venable, to consider, study, and review matters involving departmental policies. Sometimes these policy questions are initiated by the Council or they may be referred to the Council for study.

The Council consists of an engineer, a dentist, a hospital administrator, a nurse, and an epidemiologist. They serve for two years and may be reappointed. Ex-officio members include the director-emeritus, deputy director, assistant to the director, director of the Mental Health Division, and deputy civil defense director.

In addition there are two members-at-large appointed annually for a one year term. These are selected by the director from nominations made by the branch, service and section directors. Dr. Venable, although not a member of the Council, has the privilege of

meeting with and bringing matters before the group at all times.

Officers of the Council include a chairman, vice-chairman, and a secretary, each elected by the members of the Council for a one year term. Meetings are held monthly, but special meetings may be called at any time.

The group has an agenda committee composed of the officers. Any employees of the Health Department may submit in writing to any member of this committee a request or suggestion for consideration concerning any matter involving departmental policies. The agenda committee at its discretion may invite individuals to appear before the Council and present their views.

The current officers are: chairman, Dr. W. J. Murphy, director, Epidemiology Service; vice-chairman, Dr. S. C. Rutland, deputy director, and secretary, James M. Sitton, director of Hospital Service.

Employees should keep in mind that the Council is not a substitute for regular channels of administration and will consider only matters pertaining to department policy. The Council does, however, assure every employee the opportunity to have his views on departmental policies known and discussed by those making decisions for the Department.



legal page

PATIENTS' CONFIDENTIAL COMMUNICATIONS

John L. Moore, Jr., *Atlanta*

ABOUT HALF THE STATES of the United States protect confidential disclosures of patients to physicians of matters necessary for treatment. Half of the states, including Georgia, do not protect such disclosures and the physician can be compelled to testify concerning them. However, Georgia protects disclosures to a licensed applied psychologist by his client. In 1959, the Georgia General Assembly adopted an Act protecting patients' disclosures to a psychiatrist. Because disclosures to psychiatrists are protected but to other physicians are not, it would seem appropriate to discuss whether there should be a broadening of the protection in Georgia.

The argument against the "privilege" for confidential communications to physicians is well expressed by the leading legal writer in the field, Professor Wigmore. He argues that only in a few instances is the fact communicated to a physician confidential in any real sense. He points out that doctors, by other statutes, must disclose facts concerning venereal disease, criminal abortion, and questions of vital statistics. He points out also that most patients would make disclosures to their physicians even if no privilege existed. This apparently must be true in Georgia where the privilege does not exist. Professor Wigmore concludes that, if there is no privilege, the injury to the relation between physician and patient is not greater than the injury to justice if there is a privilege.

The principal argument in favor of the confidentiality of the relation of physician and patient is that

the patient will feel freer to make necessary disclosures if he can be sure that the physician cannot be compelled to disclose embarrassing or dangerous facts.

Where the privilege does exist, complicated problems can arise. For example, it is generally true with the physician-patient and client-attorney privilege that the request for assistance in a criminal act is not privileged. If the client approaches an attorney asking him to assist in a clever forgery, the attorney can be compelled to testify to the conversation at the trial of the client for forgery.

A similar example can be imagined with respect to the new privilege for the confidential relation between patient and psychiatrist. Suppose a patient comes to a psychiatrist with a request that the psychiatrist advise an abortion. Abortions are criminal in Georgia unless necessary to preserve the life of the mother. If the mother is so very ill as to make it genuinely necessary for an abortion to be performed, the patient's request to the psychiatrist is lawful and the privilege would apply. If, on the other hand, the abortion would only be necessary for what might be called social reasons and not to preserve the life of the mother, the abortion would be criminal. If the therapeutic abortion is performed and an indictment brought against the surgeon, the psychiatrist on the stand may have a delicate decision. If he insists on the privilege and his decision that the abortion was necessary to save the life of the mother is wrong, he is subject to penalty for con-

Prepared at the request of the Medical Association of Georgia. Mr. Moore is an associate in the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.

tempt. If his decision as to therapeutic abortion was correct, he would be guilty of a breach of ethics and law if he disclosed confidential knowledge contrary to the desires of his patient. Actually, this problem will very seldom arise because normally the patient will waive the privilege in order to cooperate with the prosecution. The question usually arises in cases where the patient died.

A compromise has been reached in North Carolina where a broad privilege is available to physicians and

surgeons, but with this proviso:

"... provided that the presiding judge of a superior court may compel such disclosure if in his opinion the same is necessary to a proper administration of justice."

The American Bar Association's Committee on the improvement of the law of evidence recommended use of the North Carolina proviso. It is the writer's opinion that a privilege should be afforded to confidential disclosures of patients to all licensed medical doctors in Georgia, and that the North Carolina proviso be added. In practice that proviso has worked well.

A.M.A. LAUNCHES NEW CAMPAIGN TO HELP PUBLIC CUT HEALTH CARE COST

THE AMERICAN MEDICAL ASSOCIATION announced recently that it is launching a "comprehensive study and action program" to guide the consumer in spending his health care dollars more wisely.

The AMA News, the newspaper of the medical profession, said editorially that "the program, dedicated to promoting the highest quality health care at the lowest cost, can help the consumer dramatically reduce his expenditures on health care without lowering the quality or effectiveness of it one bit."

Purpose of the campaign, part of a program announced earlier this year with the appointment of an A.M.A. Commission on Medical Care Costs, is to arm the consumer with facts in the hope that he will use them.

Purpose of the new commission on costs is "to find answers to the many questions being raised about medical care costs and to present the findings frankly and forthrightly to the medical profession and to the public."

Commission chairman, Dr. Louis M. Orr, Orlando, Fla., summarized the commission's attitude when he said:

"I do not think there should be any 'sacred cows' in medical practice, or in hospitalization, when it comes to providing medical care and services. We seek the best quality; the most quantity at the lowest possible costs. Any barrier that stands in the way of this objective should be removed—immediately."

One of these barriers is the ineffectiveness of a vast number of non-prescription or over-the-counter drug products which the A.M.A. says is currently being used by the public in great quantities and at a cost running into millions of dollars annually.

The A.M.A. called upon the nation's physicians to alert the public, their patients, the latent dangers involved in self-prescribing some of these products.

The A.M.A. said physicians also owe it to their patients to discourage them from "throwing their money

out the window" on devices, so-called "cures," food fads, "health literature," and many other forms of quackery currently bilking the American public out of additional millions of dollars a year.

The AMA News editorial said in part:

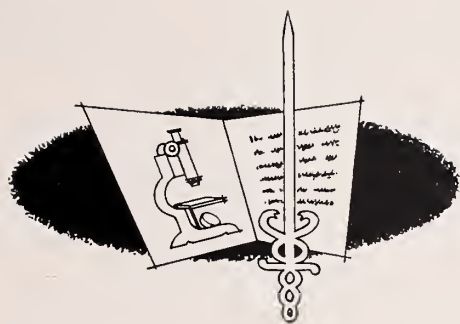
"The quackery, food-faddism phase of the program is a continuation of a concerted, nationwide campaign against door-to-door peddlers, self-styled health and nutrition experts, and manufacturers of useless devices and gadgets being promoted as "cure-alls" for everything ranging from "that tired feeling" to arthritis and cancer.

"Physicians are being asked to tell their patients the truth about vitamins, rheumatism, and arthritis remedies, and other products being bought by the public and which are essentially worthless in terms of preserving health, relieving pain and suffering, and knocking out disease.

"After a three-year study on vitamin preparations, A.M.A.'s Council on Foods and Nutrition said that if a healthy individual's diet contains the key food groups in sufficient amounts, nutritional supplementation is unnecessary. The council also believes the vast majority of people now using self-prescribed vitamins are enjoying that diet and that much of the estimated \$350 million a year the public spends on vitamins could better be spent on food.

"Americans spent more than \$148 million for laxatives and elimination aids in 1958, and at least 100 million persons have become addicted to unnatural elimination aids, Dr. Charles W. Hock, Augusta, Ga., wrote in the current issue of *Today's Health*. He warned of the dangers of self-medication and said the public should be advised to leave their digestive and elimination systems alone."

"The goal of the A.M.A. program is a higher quality of health care for a greater number of people at a lower cost."



cancer page

CONCERNING PAROTID GLAND TUMORS

Everett L. Bishop, M.D., *Atlanta*

EXCEPT IN THE MAJOR cancer centers and some of the larger hospitals where there are many referrals and material is concentrated, tumors of the parotid gland are not numerous and the individual practitioner rarely sees one for they constitute less than one per cent of all tumors. The laity hears little or nothing about salivary tumors, and physicians in general have had scant experience with their diagnosis and treatment. Many such tumors have been unsuspected and their true nature unknown until a long standing "lump" in front of or below the ear has been removed.

In many ways, parotid tumors (and tumors of other salivary glands) are peculiar. More than 50 years ago, Sir John Bland-Sutton wrote "These tumors are a pathological puzzle and the source of much unsatisfactory speculation." Some years later, McFarland, who did such extensive work on these tumors, called them "mysterious," and more recently they have been described as "confusing." All of these descriptive terms are justifiable with this group of uncommon but, in general, serious tumors.

Of all tumors of salivary gland tissue, the great majority of them occur in the parotid gland. Most of them are of the so-called "mixed tumor" type, about which there is considerable disagreement. Some of

these are considered benign and others malignant, although there is no universal agreement. There are those who consider them all malignant to varying degrees, in spite of the fact that many of them never metastasize, respect the capsule and have not recurred after years. Yet an occasional histologically benign mixed tumor *has* metastasized with its original and believed benign character maintained!

In spite of the mixed character of these tumors, they are believed to be of epithelial origin with metaplasia, edema, etc., accounting for the marked variability of their cellular make-up. Of course, there are certain parotid tumors which are frankly malignant, recurring, and metastasizing and rightly classed as adenocarcinomas of various types and the rather recently recognized mucoepidermoid tumors of low and high malignancy. The remaining small percentage of tumors in these glands includes various types of adenomas and rarely mesodermal tumors may be encountered, although true sarcoma, *primary* in salivary gland tissue may be questioned. Most so-called sarcomas of salivary glands prove to be atypical carcinomas, a metastasis or an invasion from without.

Space does not permit a lengthy discussion of these interesting tumors but it seems pertinent to call

Approved by Professional Education Committee, Georgia Division, ACS

attention to the two things essential for their cure. The first of these is the *responsibility of the patient*. These tumors are insidious in their onset, most of them extremely slow in their growth and painless as a rule. Yet, who, in looking into the mirror daily, could fail to notice a little swelling in the preauricular area? And particularly that it does not subside but slowly enlarges? The second "danger signal" of the American Cancer Society is "any lump or thickening in the breast *or elsewhere*." Yet it is a sad thing that so many of these patients delay or neglect seeking medical advice and examination until the disease is well advanced and perhaps the tumor has reached a massive size. In some series of cases, it is to be noted that there has been an *average delay of three to as high as seven years* between the time the swelling was first noticed by the patient and examination by the physician. Certainly, prompt reporting to their physician *is* the patient's responsibility. More lay or public education is needed for so many patients consider a painless nodule as insignificant; some have the feeling that it could not happen to them, or they may even have a fatalistic attitude and try to hide it as long as possible.

The second responsibility is that of the surgeon. Mixed tumors are notoriously unresponsive to radiation therapy and very few carcinomas regress to any extent, so surgery is the only curative therapy. Radiation should be used only as an adjunct in certain cases of inoperability, repeated recurrences or refusal of the patient to submit to surgery.

The tumor must be *completely* removed in order to effect a cure and to prevent what may be long delayed but eventually disastrous results. While

many tumors seem to be well encapsulated, this may be deceiving for the capsule may be incomplete or extremely thin in places or the capsule may be already invaded by the tumor from within. Or the tumor may have penetrated the capsule and invaded the surrounding salivary tissue. Some of the tumors may be completely lacking of a capsule and a few of them seem to arise from multiple foci in the gland. Surgical removal means not only removing the tumor but as much of the surrounding salivary tissue as possible. Except in the cases of multicentric origin, the frequent recurrences do not indicate a new tumor but inadequate removal at the first surgical attempt. Recurrences may be long delayed, even many years, and with recurrence there may or may not be increased activity and/or even full malignancy. Simple enucleation of the tumor should not be attempted and removal of only a millimeter or two of surrounding tissue is definitely inadequate. Fear of damaging the facial nerve or of salivary fistula undoubtedly is the basis of inadequate removal in many cases. Of course the surgeon should protect himself by informing the patient of these rare but possible dangers. This *complete* removal is therefore the responsibility of the surgeon.

Most of the "mixed tumors" can be and undoubtedly are cured; many of them after one or more recurrences, but each recurrence makes the task more difficult. Carcinomas can be cured but with any parotid tumor the prognosis should be very guarded for it is very difficult for anyone to say just when a case of this kind could be safely pronounced as cured. A favorable result and outcome will depend upon prompt attention by the patient when the "lump" is first discovered, and prompt and complete removal of the tumor with an adequate amount of the surrounding tissue by the surgeon.

FEDERAL-STATE PROGRAM FOR HEALTH CARE OF NEEDY

FIVE STATES WERE ready soon after the effective date of Oct. 1 to submit plans for participation in the federal-state program of health care for the needy and near-needy aged persons which recently was enacted into law. The states were Arkansas, Michigan, New Mexico, Oklahoma, and Washington.

As of early October, another 25 states were preparing to consider legislation to set up such a program or had indicated a willingness to proceed without new legislation. They were Alabama, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Montana, Nevada, New Jersey, North Dakota, North Carolina,

Ohio, Pennsylvania, Rhode Island, Utah, West Virginia, Virginia, and Wyoming.

Arthur S. Flemming, Secretary of Health, Education and Welfare, urged all states to take part in the program as soon as possible. But he also said he hopes that Congress in the next session will approve a Republican plan for a supplementary federal-state program to help provide private health insurance for elderly persons who cannot meet their medical expenses.

It appears that the issue probably will arise in Congress next year because some Democrats also have said they will again sponsor legislation that would provide health care for aged persons through the Social Security system.



current clinical concepts

Physiopathology of Stress Incontinence

IN MOST CASES OF stress incontinence, there is an abnormally short urethra when the patient assumes the standing position. A simple operative procedure has been performed which prevents the urethra from shortening when the patient gets to her feet.

Lapides, Jack, et. al.: Physiopathology of Stress Incontinence, S.G. and O. III:224, 1960.

The Third Kidney Phenomenon of the Gastrointestinal Tract

BEWARE OF THE vicious intake—output cycles, which can occur during parenteral replacement of fluids lost from the gastrointestinal tract of patients with certain disease and traumatic states. Severe oliguria may accompany the intake—output cycles, but all can be corrected by early diagnosis of fluid embalances and acid base disturbance. Reduction in both the intravenous intake and the gastric output is necessary to break the cycle.

Berry, Robert E. L.: The Third Kidney Phenomenon of the Gastrointestinal Tract, Arch. Surg. 81:41, 193, 1960.

A New Tracheostomy Tube in Treatment of Retained Bronchial Secretions

TRACHEOSTOMY IS NOW commonly performed for lower respiratory obstruction due to retained secretions. The conventional tracheostomy may lead to serious and even fatal complications. The interference with cough mechanism and ciliary actions are some of the complications. This recently introduced tube is designed to preserve the patient's ability to speak and to raise his own secretions by effective coughing. In addition it provides a means for obtaining the patient's bronchial secretions which he cannot raise himself. It is a straight plastic tube which fits just inside the anterior aspect of the trachea with a flange both on the inside and the outside to hold it in place.

Kistner, Robert L., Capt., USAF (MC) and Hanlon, C. Rollins, M.D., Arch. Surg. 81, 1960.

Periodic Disease and Uremia

PATIENTS WITH PERIODIC disease may develop urinary symptoms and may die as a result of renal failure . . . The kidneys in both autopsies showed severe amyloid

infiltration involving the glomeruli and the smaller vessels.

Tuqan, N. A.: Periodic Disease. A Clinical Pathologic Study, Ann. Int. Med. 49:885-889, 1958.

Sickle Cell Crises

TWENTY-TWO OF 23 consecutive admissions of patients with sickle cell anemia in acute hemolytic crisis had various infections, with the respiratory tract predominating. Most were in acute stages or complications of coryza.

Wright, C-S. and Gardner, E., Jr.: A Study of the Role of Acute Infections in Precipitating Crises in Chronic Hemolytic States, Ann. Int. Med. 52:530-537, 1960.

Radical Neck Dissection for Cervical Lymph Node Metastases of Intraoral Carcinoma

A MORE VIGOROUS attempt should be made to eradicate the primary intraoral lesion. Surgical excision should be carried out whenever the functional end-results is compatible with the patient's health and happiness. A complete radical neck dissection should be done only when neck nodes are or become palpable. Vigorous retreatment of the primary lesion should be carried out when biopsy is positive.

Palmer, John D., M.D. and Martin, S. Jameson, M.D.: Radical Neck Dissection for Cervical Lymph Node Metastases of Intraoral Carcinoma, Arch Surg. 81, 1960.

Myasthenia Gravis Thymectomy Techniques

THE QUESTION OF thymectomy and the treatment and control of myasthenia gravis is still an unsettled issue. However, it is the consensus of opinion at the Massachusetts General Hospital and The Mayo Clinic that thymectomy in this country has been reserved for the young females, without thymoma, with myasthenic syndrome of less than five years duration. The authors also pointed out that the young male may be as readily helped as the female. One indication for thymectomy which was certainly advocated is the presence of a concomitant thymoma. The reason for this is the high rate of gross malignancy in this particular group. A group was reported that gross malignancy of 25 per cent occurred in thymomas in patients without myasthenia gravis and a 75 per cent malignancy rate in patients with myasthenia gravis. This high incidence of malignancy in the myasthenic demands prompt thy-

mectomy regardless of what effect it may have on the patient's myasthenia gravis. An obligatory tracheostomy is usually performed to prevent any need for emergency tracheostomy with the patient in extremis. The withholding of all cholinergic drugs during the operation and the immediate postoperative period was also emphasized and the use of the compact positive-pressure respirators has made postoperative nursing care of these patients' more manageable.

Kreel, Isadore, M.D.; Genkins, Gabriel, M.D.; Osserman, Kermit E., M.D.; Jacobson, Elliott, M.D., and Baronofsky, Ivan D., M.D., Arch. Surg. 81, 1960.

Abnormal Eye Findings in Cystic Fibrosis

ABNORMAL OCULAR FUNDI changes were found in all 24 patients with cystic fibrosis of the pancreas in this reported series. The impression of the authors is that this finding is one of relation to pulmonary insufficiency. The findings consisted of either edema of the nerve head or tortuosity of retinal vessels.

Bruce, G.M., et al., A.M.A. Arch. Ophth. 63:391 (March) 1960.

Postsplenectomy Infections

SPLENECTOMY CARRIES A relatively low risk of postoperative infection when performed after six months of age for generally accepted indications of splenic rupture, congenital spherocytic anemia, and idiopathic thrombocytopenic purpura. In those splenectomized patients with underlying diseases predisposing to infection 27 per cent suffered severe post operative infections.

Robinson, T. W. and Sturgeon, P., Pediatrics 25:941 (June) 1960.

The Treatment of Fractures and Dislocations

THE GENERAL PRACTITIONER will find in this series of three papers a comprehensive appreciation of contemporary treatment of all types of fractures and dislocations as well as an intelligent and entertaining review of the literature.

Banks, Henry and Quigley, Thomas B., The New England Journal of Medicine No. 8:263, Aug. 28, 1960.

Dangers of Antimicrobial Therapy

THE ADMINISTRATION OF antimicrobial agents results in gross disturbances of the normally present microbial flora. This occurs especially following the use of the broad-spectrum antimicrobial agents, such as the tetracyclines and chloroamphenacols. The consequences of such disturbances are usually two-fold. Firstly, an overgrowth of the naturally resistant members of the host's normal flora may occur and result in a progressive, endogenous infection. Secondly, the host becomes more susceptible to progressive exogenous infection with certain bacteria and fungi which are unable to initiate a progressive infection in the normal host, presumably because of the antagonism or competition from the established flora.

Simon, H. J.: Attenuated Infection, The Germ Theory in Contemporary Perspective, J. B. Lippincott Co., 1960.

Serum Globulins

AN OVER-ALL GLANCE at the globulins gives the impression that their reaction to disease is a general increase. Thus the *a* globulins are elevated when any challenge to the protein homeostatic mechanism occurs; the *B* globulins reflect inefficiencies in lipid transport; and the gamma globulins reflect the responses of the reticular endothelium system to foreign or autologous irritants. The initial hope that physical-chemical methods—first solubility, then ultra centrifugation and electrophoretic analysis—would give rise to a large number of diagnostic tests for specific diseases has been disappointing. Only a few diseases, such as myeloma, nephrosis, and liver disease, cause such gross abnormalities in protein metabolism that characteristic changes can be detected by salting-out or electrophoretic methods.

Peterman, M. L.: Alternations in Plasma Protein Patterns in Disease, Putnam, F. W. (editor), The Plasma Proteins, Academic Press 2:17, 1960.

Treatment of Chronic Pyelonephritis

TREATMENT OF CHRONIC pyelonephritis with a mixture of drugs is unlikely to cure more patients than the use of a single agent that is effective *in vitro*. Bacteriologic relapse after treatment with a combination of antibiotics was more often due to new strains or strains previously present in insignificant numbers than when a single drug was used . . . short-term treatment cured one-half of the patients with chronic pyelonephritis. . . . The simultaneous administration of multiple drugs increases the incidence of adverse reactions to treatment.

McCabe, W. R.; Jackson, G. G., and Griebble, H. G.: Treatment of Chronic Pyelonephritis, Archives of Internal Medicine 104:710, 1959.

Parasitism

GREAT FLEAS HAVE little fleas upon their backs to bite 'em

And little fleas have lesser fleas, and so *ad infinitum*.

And the great fleas themselves, in turn, have greater fleas to go on;

While these again have greater still, and greater still, and so on.

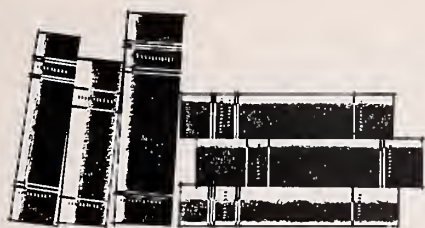
Morgan, Augustus D.: A Budget of Paradoxes.

ATTENTION PHYSICIANS FILING MEDICARE CLAIMS

**Consult MEDICARE DIRECTIVE XII
for help on completing
Medicare claim forms.**

A directive has been mailed to all physicians. If you did not receive this directive write:

**Medical Association of Georgia
Medicare Department
938 Peachtree Street, N.E.
Atlanta 9, Georgia**



physician's bookshelf

BOOKS RECEIVED

Manhold, John H., Jr., D.M.D., M.A., F.A.C.D., **OUTLINE OF PATHOLOGY**, W. B. Saunders Co., Philadelphia, Pa., 1960, 340 pp., \$4.75.

Rosenstock, Irwin M.; Hochbaum, Godfrey M., and Leventhal, Howard, **THE IMPACT OF ASIAN INFLUENZA ON COMMUNITY LIFE**, U.S. Government Printing Office, Washington, D. C., 1960, 98 pp.

Greenhill, J. P., M.D., F.A.C.S., F.I.C.S. (Hon.), **OBSTETRICS**, W. B. Saunders Co., Philadelphia, Pa., 1960, 1,098 pp., \$17.00.

Scholz, Roy O., M.D., **SIGHT: A HANDBOOK FOR LAYMEN**, Doubleday & Co., New York, N. Y., 1960, 166 pp., \$3.50.

Johnstone, Rutherford T., M.D. and Miller, Seward, E., M.D., **OCCUPATIONAL DISEASES AND INDUSTRIAL MEDICINE**, W. B. Saunders Co., Philadelphia, Pa., 1960, 482 pp., \$12.00.

Snively, William D., Jr., M.D., **SEA WITHIN: THE STORY OF OUR BODY FLUID**, J. B. Lippincott Co., Philadelphia, Pa., 1960, 150 pp., \$3.95.

Fischer, Carl C., M.D., **THE ROLE OF THE PHYSICIAN IN ENVIRONMENTAL PEDIATRICS**, Landsberger Medical Books, Inc., New York, N. Y., 1960, 122 pp., \$5.50.

Offen, J. Allan, M.D., **ADVENTURE TO MOTHERHOOD: THE PICTURE-STORY OF PREGNANCY AND CHILDBIRTH**, Taplinger Publishing Co., Inc., New York, N. Y., 1960, \$2.95.

Bierring, Walter L., M.D., M.A.C.P., M.R.C.P., Edin. (Hon.), **RYPINS' MEDICAL LICENSURE EXAMINATIONS**, J. B. Lippincott Co., Philadelphia, Pa., 1960, 805 pp., \$11.00.

Blum, Richard H., Ph.D., **THE MANAGEMENT OF THE DOCTOR-PATIENT RELATIONSHIP**, McGraw-Hill Book Co., Inc., 1960, \$8.50.

REVIEWS

Hochberg, Lew A., M.D., **THORACIC SURGERY BEFORE THE 20TH CENTURY**, Vantage Press, New York, N. Y., 1960, 858 pp., \$15.00.

THIS IS THE FIRST complete history of thoracic surgery which extends from the first recorded treatise on Egyptian surgery (Smith Papyrus) supposedly written between 1600 and 3000 B.C. to the 20th Century.

Twenty years of research were necessary to produce this fascinating story and the numerous illustrations it contains.

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

The longest chapter is on empyema thoracis. Many of the fundamental principles upon which present day thoracic surgery is based were learned by experience from surgical procedures performed for empyema in the earlier centuries, particularly the 19th Century. In 1893, Delorme and Fowler independently reported the procedure of decortication. Except for a brief reintroduction in World War I, it was abandoned until 1943 when, during World War II, its application proved useful in reexpanding hundreds of collapsed lungs.

Boldness and brilliance were not lacking among some of the earlier surgeons, especially in the 19th Century. Cervical esophageal lesions, pericardial effusions, and purulent pericarditis were treated by surgical measures. It was shown that the heart would tolerate suturing of wounds. Milton in 1897 predicted plastic operations upon the valves of the heart.

The volume would not be complete without presenting the non-surgical contributions which were so essential for the advancement of thoracic surgery. The final chapter discusses the following 19th Century non-surgical contributions: percussion, auscultation, antisepsis, anaesthesia, vital capacity, peroral endoscopy, and x-rays.

Richard King, M.D.

Mulholland, John H., M.D.; Ellison, Edwin H., M.D., and Friesen, Stanley R., M.D., **CURRENT SURGICAL MANAGEMENT II**, W. B. Saunders Co., Philadelphia, Pa., 1960.

VOLUME II OF "Current Surgical Management" represents a continuation of Volume I in which various authors presented their viewpoints in regard to some of the controversial subjects in the field of surgery. Most of this book evaluates material not covered in the original volume. There is extension of the controversy on several of the previously evaluated more popular subjects—including duodenal ulcer and carcinoma of the breast.

Material covered includes many of the problems frequently observed by all surgeons. The various viewpoints are those of recognized authorities or leading proponents of the different theories or methods presented. In most instances stress is placed on methods of and evaluation for treatment.

As the various sections are read it becomes apparent that many of the "raging controversies" primarily represent differences in evaluation of statistics encountered

PHYSICIAN'S BOOKSHELF / Continued

or in fundamental differences inherent to the economic, social, and physical situation of the patients evaluated. An example of almost parallel agreement in a controversy is illustrated in the section on intestinal obstruction.

The book is recommended as good reading for all interested in general surgery. The book reminds us that the solution of surgical problems, the goal of all, remains a complex and continuing problem.

The book is replete with critical observation of good men whose well documented and excellently presented controversy tends to invalidate the dogmatic approach to most surgical problems.

Jack A. Thompson, M.D.

Grace, William J., M.D., PRACTICAL CLINICAL MANAGEMENT OF ELECTROLYTE DISORDERS, Appleton-Century-Crofts, Inc., New York, N. Y., 1960, 132 pp., \$4.95.

THE PURPOSE OF THIS monograph is to provide the average physician with a guide to the bedside management of electrolyte problems. To this end, the author approaches the subject with a description of the important clinical entities in electrolyte disorders. Pathophysiology is given brief treatment, the emphasis being laid on recognition of the clinical syndromes and their management.

The subject matter is divided into ten sections dealing with the various types of electrolyte derangements encountered in clinical medicine. Each section is illustrated with ample case reports and examples. Simplicity of style and presentation are outstanding attributes of the writing.

On the other hand, simplicity can be over-done, for with it comes some degree of arbitrariness. An example of this is to be found in the first section. Here the author expresses his views advocating the use of intravenous ammonium chloride in the treatment of metabolic alkalosis due to the loss of gastric juice. Little justice is given to an alternate therapy using sodium and potassium chloride. There is not a word of caution on the possible danger of using ammonium chloride in individuals having renal damage or liver disease.

On balance, this monograph is recommended as a simple review of the management of electrolyte dis-

orders; however, its simplicity hampers its use in a field where complexity is the rule.

Benjamin D. Saffan, M.D.

Schaffer, Alexander J., M.D., DISEASES OF THE NEWBORN, W. B. Saunders Co., Philadelphia, Penn., 1960, 878 pp., \$20.00.

THIS BOOK IS a timely and welcome addition to the literature of pediatrics. The chapters on respiratory diseases and cardiovascular problems are valuable descriptions. No other single discussion of these numerous and complex conditions is at once so inclusive. Other portions of the text are similarly valuable in coverage and organization of material.

The clinical aspects of the diseases are covered as extensively as are the discussions of basic pathophysiology involved and management of the disorders.

The fact alone that 878 pages can be devoted to the discussion of diseases of the newborn is an indication of the extensive advances made in this particular realm of pediatrics in recent years.

Preston D. Ellington, M.D.

Anderson, W. A. D., M.D., F.A.C.P., F.C.A.P., SYNOPSIS OF PATHOLOGY, The C. V. Mosby Co., St. Louis, Mo., 1960, 876 pp., \$9.25.

THIS BOOK IN its fifth edition has been revised to include many of the facts evolving in the rapidly changing concepts of modern medicine.

It consists of 25 chapters of 876 pages including the index and references.

As stated in the preface to the first edition, this volume is intended to fill a gap which existed between the very elementary manuals of pathology and the larger text books and references. It was designed to be useful to the medicine student, the dental student, and to the clinician.

This volume is of small size with colorful and flexible binding. The paper is glossy and the print easily readable.

Most of the photographs are satisfactory and clearly serve their purpose. The text matter is clear and succinct.

This book accomplishes its purpose very nicely and is recommended to those who require a quick and brief coverage of the pathological features of diseases.

John T. Goodwin, M.D.

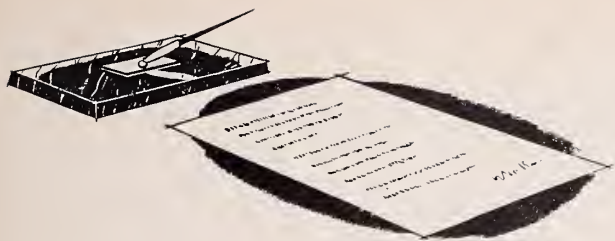
CRAWFORD LONG MUSEUM CONTRIBUTIONS

THE COMMITTEE FOR THE Crawford W. Long Memorial Museum wishes to take this opportunity to sincerely thank those of you who contributed in response to our letter calling for funds. Your response has made it possible for us to continue operation of the museum.

To those of you who have not yet contributed, your

contributions should be made payable to the Crawford W. Long Memorial Museum Association and mailed to Lester Rumble, Jr., M.D., Chairman, Crawford W. Long Memorial Museum Committee, c/o the Postmaster, Jefferson, Georgia.

J. M. A. GEORGIA



abstracts by georgia authors

Daniel, Ernest F., M.D., 811 N. Jefferson Street, Albany, Georgia, and Smith, George S., M.D., Augusta, Georgia, "Foreign-Body Granuloma of Intervertebral Disc and Spinal Canal," *J. Neurosurg.* 17:480-485 (May) 1960.

A case reported of granuloma made up of deteriorated disc and lead from a shotgun pellet. This gradually blocked the spinal subarachnoid space.

Of interest was the fact that the lead was apparently altered in form and deposited a soft mass that was highly radio-opaque.

Williams, R. C., M.D., Georgia Department of Public Health, Atlanta, Georgia, "Fifty Years of Medicine in Retrospect," *Jour. of the Med Assoc. Ala.* 8:71-77, 1960.

Important advances have taken place in the science and practice of medicine during the past 50 years. A number of diseases common 50 years ago (1910) in the United States are almost unknown at present. This includes malaria, typhoid fever, pellagra, diarrhea and enteritis, scarlet fever, and smallpox.

The five leading causes of death in 1910 were: heart disease, pneumonia and influenza; tuberculosis (all forms), diarrhea, enteritis and ulceration of intestines, and nephritis (all forms). Only heart disease still remains in the first five leading causes of death.

Eighty per cent of the drugs now in use by physicians were unknown 20 years ago. Only two or three of the drugs appearing on the 1910 list of drugs most commonly used are found to be in general use at present.

Profound changes in medical education have occurred during the past half century. There were 154 medical schools in the United States 50 years ago; at present there are 85 medical schools. There were about 21,000 medical students and 4,436 graduates in 1910. For 1960, there are almost 30,000 medical students and about 7,000 graduates. The students themselves are somewhat older; from three to 16 per cent of first-year medical students now are married when they enter medical school. By the time the fourth year is reached, as many as 75 or 80 per cent may be married. Fifty years ago hardly more than one or two men in each class were married.

Certain diseases formerly considered inevitable, have almost disappeared, such as diphtheria, meningitis (all forms), tetanus, and surgical mastoiditis. Surgical procedures beyond the

flight of fancy, are now routine. Drugs, which are still called miracle, are in every physician's handbag.

Surgical operations within the heart are commonplace. Repairs and corrections on valves of the heart are routine. Sections of the large blood vessels near the heart are readily replaceable. Operative procedures within the cranium for cerebrovascular accidents and other conditions are in common use.

The next 50 years will doubtless see equally as much astounding progress.

Yampolsky, Joseph, M.D. and Perry, Samuel W., M.D., 101 Third Street, N.E., Atlanta 8, Georgia, "The Treatment of Poisoning in Children by Exchange Transfusion," *South. M. J.* 53 (Sept.) 1960.

The authors reviewed the literature on the use of exchange transfusion for the cure of ingestion of numerous drugs. The consensus of opinion is that the therapeutic value of exchange transfusion is assured when used in proper cases, since extracorporeal dialysis is not available in emergencies. Exchange transfusion in those cases may be lifesaving. While the concentration of the ingested in the blood is of importance they feel that many patients with low concentration, but presenting physical signs of severe intoxication, may be helped by exchange transfusion. One may begin by attempting to improve the electrolyte imbalance, but when the concentration of the intoxicant remains high and the patient does not respond, exchange transfusion may be invaluable as a therapeutic agent.

A case is presented of methyl salicylate ingestion. The lethal dose of this drug is infinitesimal. Although they tried for some hours to correct the electrolyte imbalance and to reduce the salicylate level in the blood, which was initially 164 mg. per 100 ml., the patient seemed to fail and a blood exchange was then done. The blood salicylate fell to 77.6 mEq./L. the next day and the symptoms had almost disappeared. The patient made a full recovery.

The authors suggest that exchange transfusion is one more method in reducing the fatalities in intoxicating ingestants.

King, James T., M.D., 340 Boulevard, N.E., Atlanta 12, Georgia, "Acute Staphylococcal Frontal Sinusitis with Fulminant Fatal Subdural Abscess," *Arch. Otolaryng.* 72:356-357 (Sept.) 1960.

A 16-year-old semiconscious white youth, who had been sick only two

days, was hospitalized because of suspected meningitis secondary to frontal sinusitis. Shortly thereafter, as antibiotic treatment was instituted and surgical exploration considered, he developed sudden central respiratory paralysis with cardiac arrest. Although massage revived cardiac rhythm, he died in a few hours in deep shock.

At autopsy an overwhelming subdural abscess was found from which coagulase positive staphylococcus (strain 80/81) was cultured. One year previously his mother had developed a "staph" wound infection following nephropexy which required prolonged treatment. About a month before her son's illness, she was taken with hidradenitis suppurativa of the right axilla which produced the identical organism to that of her son's infection.

Schafer, H. H., M.D.; Witham, A. C., M.D., and Burns, J. H., M.D., Medical College of Georgia, Augusta, Georgia, "Digitalis Tolerance and Effect of Acetyl-Strophanthidin Upon Serum Potassium of Dogs with Acidosis and Uremia," *Am. Heart J.* 60:388-395 (Sept.) 1960.

Rapid digitalization with the glycoside acetyl-strophanthidin did not consistently cause a rise in serum potassium levels in normal dogs. In contrast, similar experiments, in dogs made acidotic with ammonium chloride or by experimental uremia, resulted in serum potassium rises which were statistically significant and often dramatic. This hyperkalemia appeared to be an additive or synergistic effect of acidosis and the glycoside, both of which favor loss of cellular potassium into serum. Tolerance to the cardiac glycoside was sharply and consistently increased in ammonium chloride acidosis but not in experimental uremia. In the latter situation, however, tolerance was highly variable, unlike findings in control animals, and was related to increases or decreases in serum potassium in the uremic state. In spite of a rise in serum potassium to levels of nine to 11 mEq./L. after digitalization in 11 animals, electrocardiographic effects attributable to hyperkalemia were surprisingly rare. This finding was in marked contrast to the effects of similar potassium levels in undigitalized animals. This protection of the cardiac cell against high serum levels of potassium seems related to the membrane effect of the cardiac glycoside in blocking entry of potassium into the cell.



the association

DEATHS

WILLIAM R. DANCY, 83, one of Savannah's and Georgia's most prominent physicians, died unexpectedly September 14 in Atlanta while he and Mrs. Dancy were visiting his sister.

The son of David Yulee Dancy and Julia Remshart Dancy, he was a native Savannahian. On his maternal side he was a descendant of the first settlers of Georgia and on his paternal side a descendant of John Dancy, an original settler of Virginia.

Dr. Dancy was educated in the schools of Savannah, graduated from the University of Georgia in 1896 and from Johns Hopkins in 1900. After practicing in Brooklyn and engaging in special study in Europe at Berlin and Vienna, he returned to Savannah in 1902 to become resident superintendent of the Savannah Hospital (now the Warren A. Candler Hospital).

Active in military as well as fraternal affairs, Dr. Dancy, in World War I, organized the physical examinations for the Selective Service Board. He served as an officer of the Georgia State Militia for more than 12 years, attaining the rank of general.

Dr. Dancy was a past president of the Medical Association of Georgia, a past commander-in-chief and state department commander of Sons of Confederate Veterans, and a past commander of Francis S. Bartow Camp No. 93, S.C.V., of Savannah.

Besides heading the state medical association in 1929-30, he was president of the First District Medical Society in 1926-27 and was president of the historic Georgia Medical Society of Savannah in 1925-26. He was a fellow of the American Medical Society.

His fraternal interests included Masonry, being a past worshipful master of his lodge. He was also a member of the Ancient and Accepted Scottish Rite and of the Shrine. He was a member of St. John's Episcopal Church in Savannah.

Survivors include his wife; two sisters, Mrs. Fred A. Hoyt, Atlanta and Mrs. J. Hammond Eve, Savannah, and several nephews and nieces.

GEORGE WILLIAM DUPREE died September 17 at his residence in Gordon at the age of 72 after a lengthy illness.

Dr. DuPree was born in Wilkinson County, the son of John Thomas DuPree and Mrs. Percy Stanley DuPree, and had lived there most of his life. He was a graduate of Locust Grove Institute and the Emory

University Medical School. He served as a medical officer in World War I.

A member and deacon of the Gordon Baptist Church, he was also a member of the American Legion, the Gordon Lodge No. 240 F. and A.M., Scottish Rite Bodies, Al Sihah Temple, the Bibb County Medical Society, the Medical Association of Georgia, the American Medical Association, and the American Academy of General Practice.

Surviving are his wife, the former Miss Eva Kitchens of Gordon; one son, Dr. John Thomas DuPree, Macon; one daughter, Mrs. J. J. Brooks, Gordon; one brother, John T. DuPree, McIntyre; a sister, Mrs. J. C. Hunnicutt, Macon, and 10 grandchildren.

JAMES CARL PIRKLE died suddenly at the age of 48 at a local hospital in Milledgeville.

A member of the medical staff of Milledgeville State Hospital, Dr. Pirkle was an honor graduate of the 1931 class of Gainesville High School, and an honor graduate of the Medical College of Georgia. He had been a member of the staff of Milledgeville State Hospital prior to World War II, went into private practice in Pelham after returning from the Army, and returned to the staff at M.S.H. about six years ago.

Survivors include his wife, the former Miss Doris Burton; one son, James Carl Pirkle, Jr., a student at Georgia Tech; two daughters, Miss Sandra Pirkle and Mrs. John W. Ferrell, both of Milledgeville; his mother, Mrs. W. B. Pirkle, Gainesville; three brothers, Cline Pirkle, Augusta, and Felton and Ralph Pirkle both of Gainesville, and one sister, Mrs. O. A. McQueen, Bristol, Fla.

WILLIAM KIRK SWANN, 77, died August 29 at a hospital in Atlanta after a short illness at his home in Covington.

Dr. Swann, a native of Henry County, was the son of the late Thomas Green and Eleanor Austin Swann. He attended Henry County Schools and Lithonia High School, prior to joining the U. S. Armed Forces, with which he served three years in the Philippines.

Upon his return, he entered the Atlanta College of Physicians and Surgeons, now Emory University Medical School, where he received his degree in medicine.

In 1911, Dr. Swann located in Monroe and served as Walton County physician until the outbreak of World War I, in which he was commissioned as a captain with the U. S. Medical Corps. After the war, Dr. Swann resumed his practice in Monroe until his

retirement from active practice, at which time, he and his family moved to Covington.

In 1941, Dr. Swan was appointed Judge of Recorder's Court, in which position he served until the time of his death. At the beginning of World War II, he again volunteered his services, and was named as Chairman of Newton County Selective Service Board, where he continued to serve until the present time.

Dr. Swann was a member of the Methodist Church, Newton County Medical Society, and the Elks' Club.

Survivors include his wife, the former Miss Stella Upshaw of Walton County; three daughters, Mrs. Robert H. Wharton, Atlanta, Mrs. William Reid Childers, Griffin, and Mrs. W. T. Rainey, Jr., Oakridge, Tenn.; two sons, Dr. W. K. Swann, Jr., Knoxville, Tenn., and Paul Swann, Dalton; three sisters, Mrs. Clifford White, Mrs. Ed Stewart, and Mrs. Clyde Thurmond, all of Rex; three brothers, Jack Swann, Atlanta, Howard and Zed Swann, both of Rex, and 15 grandchildren.

SOCIETIES

During the September meeting of the FLOYD COUNTY MEDICAL SOCIETY, the following officers and delegates were nominated for 1961: Hobart Hortman, president; Cary Moore, president-elect; Robert J. Black, secretary-treasurer; Ralph J. Davis, delegate; R. Crawford Brock, alternate; John D. Tate, delegate; James T. Matheny, alternate; James H. Jenkins, delegate, and Harlan M. Starr, alternate. These officers and delegates will be officially elected in December.

Dean W. G. Rice of the Medical College of Georgia spoke to the GEORGIA MEDICAL SOCIETY during their October meeting on "Medical Curricula Past, Present, and Future."

The present officers of the NEWTON-ROCKDALE MEDICAL SOCIETY are: J. R. Sams, Covington, president and J. W. Purcell, Covington, secretary.

During a recent meeting of the OCMULGEE MEDICAL SOCIETY, Reid Gullatt, Cochran, was elected president for 1961. Other new officers elected were: A. S. Batts, Hawkinsville, vice-president; Blake Bivins, Cochran, secretary-treasurer, and Virgil S. Steele, Eastman, delegate to MAG.

Dr. William J. Anlyan, associate professor of surgery at Duke University, spoke to the members of the TROUP COUNTY MEDICAL SOCIETY recently on thrombo-embolic diseases.

The WARE COUNTY MEDICAL SOCIETY met recently with Mr. Dick James, Chamber of Commerce manager, as guest speaker.

The semi-annual meeting of the SECOND DISTRICT MEDICAL SOCIETY was held in October at Radium Springs in Albany with Frank Shackelford, Atlanta; Roy M. Lilly, Thomasville, and R. Emerson Gardner, Atlanta, presenting the program.

The MUSCOGEE COUNTY MEDICAL SOCIETY entertained the THIRD DISTRICT MEDICAL SOCIETY in October at the Columbus Country Club.

The SEVENTH DISTRICT MEDICAL SOCIETY met recently as the guests of the WHITFIELD COUN-

TY MEDICAL SOCIETY at the Dalton Country Club.

F. Marvin Engle, Brunswick; D. Frank Mullins, Jr., Augusta, and John R. Bottomy, Atlanta, presented the scientific program to the EIGHTH DISTRICT MEDICAL SOCIETY which met in October at the Okefenokee Golf Club.

The NINTH DISTRICT MEDICAL SOCIETY recently met at Pine Crest Inn, south of Canton, as guests of the CHEROKEE-PICKENS MEDICAL SOCIETY.

PERSONALS

First District

The personnel of Health District Seven held a picnic at Indian Bluff near Guyton recently as an informal farewell to CHARLES T. BROWN, Medical Director from Guyton, who is on educational leave at the University of North Carolina.

Second District

BLAKE FOSTER, formerly of Milledgeville, now of Pelham, has opened his office in the Howard Hospital for the practice of general medicine and surgery.

F. M. GAY, Moultrie, has moved his office to 20 First Street, S.W.

Two of the new members of the medical staff of the Phoebe Putney Memorial Hospital are JAMES B. MARTIN and FRANK D. GUILLEBEAU, both of Albany.

Third District

SIMONE BROCATO, Columbus, discussed "Post-partal Heart Disease" at a recent southeastern regional meeting of the American College of Physicians at Ponte Vedra Beach, Fla.

CLARENCE BUTLER, Columbus, was recently elected president of the Georgia Heart Association for 1961.

LEONARD T. MAHOLICK, Columbus, recently returned from Vienna, Austria where he studied logotherapy with Dr. Viktor Frankel at the University of Vienna.

BRUCE C. NEWSON, ALLEN PETWAY, and JAMES A. ELKINS, all of Columbus, are now occupying their new offices at 1905 Seventh Avenue.

MIRIAM CHAMBLESS and W. G. CHAMBLESS, of Hamilton, recently attended the three-day postgraduate course in obstetrics and pediatrics held at Daytona Beach, Fla.

A. B. CONGER, Columbus, spoke to the Muscogee Pharmaceutical Association recently on causes, symptoms, and various types of cancer.

LUTHER H. WOLFE, of Columbus, recently addressed members of the Woman's Auxiliary to the Muscogee County Medical Society on national and state medical legislation.

Fourth District

ROBERT L. BENNETT, executive director of the Georgia Warm Springs Foundation, recently received

an honorary degree of Doctor of Science at the University of Pittsburgh.

WILLIAM B. FACKLER, JR., LaGrange, recently took part in a conference on cardiac clinics at the 12th Annual Meeting of the Georgia Heart Association held at Savannah.

ULRICH H. HARTE, Newnan, recently attended the seminar on obstetrics and pediatrics held at Daytona Beach, Fla.

Fifth District

HELEN W. BELLHOUSE, Atlanta, was one of the sponsors of the seminar on obstetrics and pediatrics held recently at Daytona Beach, Fla.

RIVES CHALMERS, Atlanta, introduced Dr. Otto A. Will, Jr., director of psychotherapy at Chestnut Lodge, Rockville, Md., who spoke to the Georgia Psychiatric Association recently on "Psychotherapeutic Principles: Their Development in the Course of Treatment."

Ben J. Massell, general chairman of the Atlanta Israel Bond Committee, has named ROSE A. LAHMAN, Atlanta, as chairman of the Women's Division for the Fall 1960 Israel Bond Drive in Atlanta.

ALEXANDER D. LANGMUIR, Atlanta, spoke on "Your Community and Preventable Diseases" to about 400 physicians and farm group representatives, who recently attended a two-day conference on rural health held in Atlanta.

Sixth District

EDMUND A. BRANNEN, of Macon, was recently selected as "Man of the Week" by the *Millen News*.

MILFORD B. HATCHER, Macon, recently spoke at the First Regional Conference on Rural Health held in Atlanta, and also recently spoke to the Macon Lions Club on "The Panorama of Medicine Today."

Hanging in the executive suite of the new Public Health Building in Atlanta is an oil painting of L. C. RIDLEY, SR., one of Macon's pioneers in the field of health and hospital administration.

RICHARD L. SMITH, of Cochran, and CURTIS F. VEAL, of Milledgeville recently attended the three-day seminar on obstetrics and pediatrics held at Daytona Beach, Fla.

Seventh District

CARL C. AVEN, Marietta, has been awarded the 1960 Southern Conference award for "outstanding contributions to TB control in the South." Dr. Aven is the fourth physician and the first from Georgia to receive the coveted award.

CECIL M. JACOBS, Dalton, is on a year's academic leave of absence for further studies in public health service at the University of North Carolina.

EVELYN M. STEPHENSON, of Dalton, formerly of Rome, has joined the staff of the Dalton-Whitfield County Hospital as a pathologist.

Eighth District

ARTHUR M. KNIGHT, JR., Waycross, is the new president of the Georgia Heart Association.

B. D. LUKE, of Blackshear, spoke to the Blackshear Rotary Club recently on "Heart Diseases."

W. LOOMIS POMEROY, Waycross, was installed as president of the Georgia branch of the American College of Surgeons at a meeting of the group held recently at St. Simons Island.

DR. and MRS. F. R. MANN, of McRae, recently attended the GAGP annual meeting held in Atlanta.

Ninth District

A. FREDERICK BLOODWORTH, Gainesville, has been elected president of the Georgia Thoracic Society for 1961.

DR. and MRS. STEWART D. BROWN, JR., of Royston, recently spent several days in New York attending the World Congress for the Welfare of Cripples.

DANIEL C. KELLEY, Lawrenceville, was honored recently at the University of Tennessee by being awarded the Golden "T" Certificate for over 50 years of service to his university and his community.

Tenth District

DR. and MRS. HERVEY M. CLECKLEY, Augusta, recently entertained a distinguished British visitor, Sir Hamilton Kerr of Cambridge and London. Sir Kerr was Dr. Cleckley's classmate at Oxford.

During the October meeting of the Women's Board of the University Hospital in Augusta, CORBETT THIGPEN spoke to the group on "Living and Our Problems of Adjustment."

FIRST REGIONAL RURAL HEALTH CONFERENCE

THE MEDICAL ASSOCIATION of Georgia was recently privileged to act as host state medical association for the First Regional Rural Health Conference for Southeastern States held in Atlanta October 7-8, 1960. Some 250 representatives of farm bureaus, agricultural extension services, 4-H Clubs, F.F.A. chapters, county, state, and federal health agencies, and county and state medical societies attended this two day program sponsored by the American Medical Association Council on Rural Health.

Main topics covered at this conference included: "Your Community and Preventable Diseases;" "Safety—Home, Work, and Play," and "Health Opportunities Through Organized Community Development Groups."

Georgia participants in the program included Milford B. Hatcher, M.D., Macon; Alexander D. Langmuir, M.D., Dorothy Jaeger-Lee, M.D., Luella Kline, M.D., and William Robert VanGorder, all of Atlanta.

Also participating from Atlanta were: James Lieberman, D.V.M., Mrs. Charles D. Center, Mr. Jesse C. Norman, Jr., John McCroan, Jr., Ph.D., Mr. William A. Hansel, and J. H. Venable, M.D.

Others included: Col. William P. Trotter and Mr. Milton D. Krueger, both of Atlanta; Mrs. S. G. Chandler, Athens; Miss Carolyn Ware, Cuthbert; Miss Mary Lou Maness, Savannah, and Mr. Earl Cheek, Jr., Perry.

COUNCIL MEETING MINUTES

THE FALL MEETING of the Council of the Medical Association of Georgia was called to order by Council Chairman J. G. McDaniel at 2:05 P.M., October 1, 1960 at the King and Prince Hotel, St. Simons Island, Georgia.

Council members present included: Milford B. Hatcher, Macon, President; Fred H. Simonton, Chickamauga, President-Elect; Luther H. Wolff, Columbus, Immediate Past President; Braswell Collins, Macon, Second Vice President; John T. Mauldin, Atlanta, Secretary; Thomas W. Goodwin, Augusta, Speaker of the House; J. Frank Walker, Atlanta, Vice Speaker of the House; Eustace A. Allen, Atlanta, AMA Delegate; Henry H. Tift, Macon, AMA Delegate; J. W. Chambers, LaGrange, AMA Delegate; T. A. Peterson, Savannah, First District Vice Councilor; George R. Dillinger, Thomasville, Second District Councilor; Willis P. Jordan, Columbus, Third District Vice Councilor; Virgil Williams, Griffin, Fourth District Councilor; J. G. McDaniel, Atlanta, Fifth District Councilor; Charles S. Jones, Atlanta, Fifth District Vice Councilor; George H. Alexander, Forsyth, Sixth District Councilor; Ralph W. Fowler, Marietta, Seventh District Councilor; F. G. Eldridge, Valdosta, Eighth District Councilor; James M. Hicks, Brunswick, Eighth District Vice Councilor; C. R. Andrews, Canton, Ninth District Councilor; Paul T. Scoggins, Commerce, Ninth District Vice Councilor; Addison Simpson, Jr., Washington, Tenth District Councilor. Also in attendance were: David Henry Poer, Atlanta, Chairman, Hospital Relations Committee; Edgar Woody, Jr., Atlanta, Editor, JMAG; John P. Heard, Decatur, Chairman, Public Service Committee; Mr. John Moore, Attorney; Mr. Milton D. Krueger, Executive Secretary, MAG; Mr. John F. Kiser, Associate Executive Secretary, MAG; Mrs. Catherine Wooten, Executive Assistant, MAG.

Chairman McDaniel called on Mr. Krueger to read the minutes of the Council meeting of June 25-26, and Executive Committee of Council meeting minutes of June 26, July 23 and August 28. There being no correction, on motion duly made and seconded, the Council and Executive Committee of Council meeting minutes were then approved.

Hospital Committee Recommendations

Dr. Poer reported on Hospital Committee recommendations and reviewed the topics of importance in the last meeting of the Hospital Committee. This report was reviewed for information and Dr. Poer was commended for these activities.

Civic Vote Campaign

Dr. Woody reported on the "Election Day Office Closing" program. He described the method of enclosing the poster with the JMAG; letters to other state editors; Dr. Hatcher's letter to county presidents and secretaries, and press release to all newspapers in Georgia. Much favorable comment had been received from other state associations concerning this project.

AMA Civil Defense Meeting

Chairman McDaniel read letter from the AMA inviting state society representatives to Civil Defense Conference in Chicago November 4-6 sponsored by the AMA. On motion (Goodwin-Simonton) it was recommended that the Association not send a representative to this meeting due to difficulties in arrangements.

Policy on MAG Member Pensions

Secretary Mauldin reported on a pensioner and recommended that this be continued as in the past. There was discussion of future cases complying with matching funds from the MAG and county society. On motion duly made and seconded, it was approved to continue the pension on a non-matching basis as an exception to the MAG ruling.

Finance Committee Report

The financial report was given by Dr. Williams. He asked for approval of \$667.00 for purchase of stationery. On motion (Hatcher-Simonton) it was voted to appropriate the \$667.00 from the contingent fund. The report was then approved.

Investment of MAG Funds Data

Dr. Williams reported on this in Dr. Arp's absence. It was Dr. Arp's recommendation that MAG purchase short term Treasury Bonds. It was recommended that this be further investigated and reported on completion of the study.

MAG Annual Session Report

Dr. Tift gave a report that the program was progressing nicely.

Dr. McDaniel recommended that the MAG have a dinner for the interns, residents, and their wives at the time of the MAG Annual Session. This would be for the purpose of getting the Atlanta group acquainted with each other and with the Medical Association of Georgia to indoctrinate them about local medical societies and national organizations. Dr. Simonton suggested that all interns, residents, and their wives over the state be invited. Fulton County has planned to invite the local group and perhaps MAG could pay half of the cost. It was recommended that Dr. Tift bring this up at his next meeting and then present recommendations at the December meeting of Council.

Athletic Injury Conference Report

Dr. Williams gave a report on the Athletic Injury meeting in Columbus, August 12-13, for Dr. Hughston, who was unable to attend. It was recommended that the Secretary write Dr. Hughston to thank him and encourage him to continue with these meetings.

Governor's Study Committee on Health Care of the Aging Report

Dr. Mauldin gave a report on the Kerr-Mills Bill as discussed at the Governor's Study Committee September 30th. This Committee was appointed by the Governor and consists of 11 members, including Dr. Mauldin, representing the Aging Commission, Dr. Chambers from MAG, Dr. O. B. Hardy, representing the Hospital Association, Mr. John Burkett, Nursing Homes, and the State Departments of Health, Welfare, Labor, and Education were also represented. The Committee is to study the bill and by December 1 recommend to the State Legislature what the Georgia Plan should be. On October 5, 1960 an AMA representative is coming to Atlanta for an orientation course on various states' plans for the operation of this program.

Mr. Kiser was invited to Chicago last week for a two day meeting of the American Hospital Association and he gave a report on this meeting for information.

Dr. Chambers reported on the September 30 meeting of the Governor's Study Committee in the Governor's office conducted by Mr. Sanders. Dr. Mauldin was appointed Vice Chairman. An open hearing will be conducted on October 11 at the Capitol and a meeting in the afternoon of the Committee after the hearing. There was discussion that a special meeting of Council might have to be called to decide on MAG policies on this matter before the January meeting of the Legislature.

AMA-MAG Alternate Delegates' Expenses

Dr. Allen discussed this and recommended that the MAG pay some of the alternate delegates' expenses. Dr. Hatcher recommended that this be referred to the Budget Committee. On motion (Allen-Wolff) it was voted to have the Executive Committee designate how much to give the alternate delegates and recommend to Council at next meeting.

AMA Delegation Chairmanship

Dr. Hatcher stated that the Executive Committee of Council recommended to the MAG Council that the Council annually designate at its December meeting, the Chairman of the AMA delegation for the following year. On motion duly made and seconded this was approved.

SAMA Funds Request

Dr. Mauldin read a letter from the Georgia President of SAMA, Robert P. Taylor, requesting funds (\$50.00) for a meeting of Region One of SAMA in October. On motion (Alexander-Collins) this was approved and further that the \$50.00 be charged to the SAMA budget item.

Influenza Immunization Data

Dr. McDaniel gave a report for information from the Influenza Fact Sheet. He requested that Dr. Woody investigate the insertion of this in the *Journal* envelope and/or write an editorial. On motion (Hatcher-Simonton) this was approved.

MAG Officers Listing Plaque

Dr. Simonton recommended that this be referred to the Executive Committee and it was approved.

Rehabilitation Committee Booklet

Chairman McDaniel informed the members of Council that Dr. Bennett wished to defer this presentation until the December Council meeting.

Chairman McDaniel recessed the meeting at 5:00 P.M.

Council Reconvened

Council Chairman McDaniel reconvened the Council meeting at 8:25 A.M. on October 2, 1960, at the King and Prince Hotel, St. Simons Island, Georgia.

Those present, in addition to those attending the meeting on October 1, were Joseph B. Mercer, Brunswick, Chairman of Standardization of Insurance Forms Committee; Mr. Franz Lipsey, Atlanta, Medicare Administrator, MAG Headquarters.

Atlanta Mental Hospital Plans

Dr. Hatcher read a letter from John H. Venable, Director, Georgia Department of Public Health, regarding request for suggestions by MAG members in regard to the Atlanta Mental Hospital. This letter was discussed. Dr. Hatcher recommended that this be referred to the Mental Health Committee with the suggestion that the Committee write Dr. Venable, with a carbon to Mr. Krueger. On motion duly made and seconded it was voted to follow Dr. Hatcher's recommendation.

Standardized Insurance Forms

Dr. Mercer reported on the progress on Standardized Weekly Insurance form. He believes it should be approved by MAG as recommended by Standard Insurance Form Committee. He also asked consideration of funds for printing small supply for use in beginning, if necessary. On motion (Alexander-Collins) it was voted to approve this recommendation. Dr. Mercer also suggested mailing a letter to MAG membership with explanation and sample insurance form. Secretary Mauldin was directed to write Mr. Sheffield Owen a "thank you" letter for his work on this matter.

Medicare Administration Improvement

Dr. Mercer explained the need for a Medicare maximum allowance "fee schedule" being published and made known to MAG membership. Mr. Lipsey discussed overall problems of fees. On motion (Hatcher-Fowler) it was voted to make up a confidential abbreviated Medicare maximum allowances schedule and insert a notice in the *Journal* that doctors may obtain maximum allowance schedule by writing the MAG Medicare Department. Dr. Hatcher recommended that Mr. Lipsey visit various medical societies and discuss this subject with them. It was recommended that the annual renegotiation be determined in advance by the statewide Review Board meeting with their recommendations subject to approval of Executive Committee. This recommendation was approved.

Public Service Committee Plans and Activities

Dr. Heard presented the Presidents and Secretaries Conference program scheduled for December 10-11, at the Dinkler Plaza Hotel, Atlanta, and invited Council to attend.

He then presented information regarding the County Medical Society Secretary's Notebook regarding type of material to be included, and cost of printing the notebook, which totalled \$2,172.40. Dr. Hatcher discussed the necessity of collecting dues before January 1, and with these improved forms, it could be accomplished at an earlier date. On motion (Hatcher-Collins) it was voted to approve appropriation of \$2,172.40 from the contingent fund. It was approved to have the Secretary write a letter to Dr. Heard commending him on this project.

Committee Reorganization Recommendations

Dr. Dillinger presented background data on problem of Committee Reorganization and discussed consolidation of standing committees. He asked for recommendations on whether to designate committees as AMA does; namely Boards or Commissions. There was general discussion of this. On motion (Williams-Alexander) it was voted to empower Dr. Dillinger's Committee to recommend any changes thought feasible.

Headquarters Office Report

Mr. Krueger reported on Headquarters personnel; meetings attended by staff; mailings for specialty societies. He also reported on data from AMA-PR meeting in Chicago on the following: (1) aging; (2) doctor-patient relations and cost of medical care; (3) physician supply and distribution (placement bureau and

medical careers); (4) mental illness; (5) national debate topic; (6) membership relations; (7) other organizations relations; (8) state and national legislation. Dr. Dillinger commended Mr. Krueger on his report and recommended that his statements about the AMA-PR meeting be mailed out to publicize these items. He recommended sending a list of the objectives with comment to each Councilor to be used as they see fit and also mail to county societies.

Other Business

(1) Report on future White House Conference on Aging by Dr. Mauldin.

(2) Dr. Dillinger reported on the present availability of hospital insurance to aged.

(3) Dr. Wolff recommended writing Georgia Nursing Association commending them for their stand against the Forand bill at the American Nursing Association's meeting. On motion (Wolff-Goodwin) it was voted to do so.

(4) On motion duly made and seconded, it was voted to hold the December Council meeting on Sunday, December 11, at 9:00 A.M., in MAG Headquarters Office Building, Atlanta.

(5) On motion (Alexander-McDaniel) it was voted to thank Dr. Eldridge for his invitation to Valdosta, but it was declined for the December meeting.

(6) On motion (Simpson-Collins) it was voted to have MAG Headquarters use name of doctor with "M.D." following his name, in correspondence; and to change plates at some date in the future.

(7) Dr. McDaniel recommended that the Secretary write Dr. Shepard and Dr. Whitaker to thank them for allowing MAG Council and guests to participate in Georgia Chapter, ACS Banquet at the Cloister, October 1.

There being no further business, the meeting of the MAG Council was adjourned at 11:35 A.M.

EXECUTIVE COMMITTEE OF COUNCIL MEETING MINUTES

THE SEPTEMBER MEETING of the Medical Association of Georgia Executive Committee of Council was called to order by Chairman Milford B. Hatcher at 11:45 A.M. on October 2, 1960 at the King and Prince Hotel, St. Simons Island, Georgia.

The members of the Committee present were: Milford B. Hatcher, Macon, President and Chairman; Fred H. Simonton, Chickamauga, President-Elect; Luther H. Wolff, Columbus, Immediate Past President; J. G. McDaniel, Atlanta, Chairman of Council; John T. Mauldin, Atlanta, Secretary, and Virgil B. Williams, Griffin, Chairman of Finance. Also present were Mr. John L. Moore, Jr., Attorney; Mr. Milton D. Krueger, Executive Secretary; Mr. John F. Kiser, Associate Executive Secretary, and Mrs. Catherine Wooten, Executive Assistant, all of Atlanta.

Regional Rural Development Program Conference

Mr. Krueger read a letter from the University of Georgia College of Agriculture concerning a Rural Development Program Conference planned for October 19-21, 1960, in Birmingham, Alabama. Albert L. Morris, Fairburn, had been invited to attend. Dr. Morris was unable to do so and on motion (McDaniel-Wolff) it was voted to send a representative from the MAG staff to this meeting.

Appointments

(a) *Poison Control Advisory Committee*: It was voted to appoint Leonard H. Campbell, Macon.

(b) *Georgia Joint Council to Improve Health Care of Aged*: It was voted to appoint E. L. Bosworth, Rome, and Henry Jennings, Gainesville.

(c) *Georgia Citizens Mental Health Committee*: It was voted to appoint Luther H. Wolff, Columbus.

(d) *Florida Citrus Commission Request*: It was voted to appoint Grady E. Black, Griffin.

(e) *Physician-Lawyer Liaison Committee*: It was voted to reappoint same committee—W. Bruce Schaefer, Toccoa; W. Loomis Pomeroy, Waycross, and Charles S. Jones, Atlanta. It was also voted to inform the Committee and if one cannot accept, Dr. McDaniel recommended Henry M. Finch, Atlanta.

(f) *Interprofessional Council*: It was voted to appoint Braswell E. Collins, Macon.

Atlanta Uptown Association, Inc. Request

Dr. Mauldin presented a letter seeking MAG participation in

this Association, which is interested in long-range programs for Uptown Area of Atlanta. On motion duly made and seconded it was voted to defer this and take it up at the next Annual Session.

AMA Relative Value Study Meeting Participants Representing MAG

Mr. Krueger read the letter from AMA regarding this meeting on November 5, 1960, in Atlanta. It was voted that the Executive Committee of MAG attend, plus David R. Thomas, Jr. and Charles S. Jones, of the MAG Insurance and Economics Committee.

At this point Dr. Simonton recommended that the November Executive Committee meeting be held on November 5 in Atlanta following the above meeting. On motion duly made and seconded it was so voted.

MAG Headquarters Property and Personnel Insurance Study

On motion (Wolff-Mauldin) it was voted to defer this report until the next meeting.

Other Business

(1) Dr. Hatcher read a letter on an insurance program from Physicians and Surgeons Underwriters Corporation on malpractice insurance coverage. It was voted to refer this to the Insurance and Economics Committee for investigation.

(2) *Plaque*: Dr. Simonton discussed the type of plaque he recommended for display in the MAG Headquarters Building. It was voted to write the firm and describe MAG requirements and get price.

(3) *Date and Site of October-November Executive Committee of Council Meeting*: November 5, 1960, MAG Headquarters Building, Atlanta, had been previously approved.

(4) *Kerr-Mills Bill*: The Executive Committee recommended that a rough draft of a Resolution be drawn up for introduction at the AMA Clinical Session by the Georgia delegation supporting this recently enacted legislation.

(5) At Dr. Hatcher's suggestion he desired to write an article for the President's Page in the Journal on "What You Can Do to Improve Patient's Care." This was approved.

(6) *Discussion on Accepting Service Members*: Secretary Mauldin was instructed to study and work with Mr. John L. Moore, Jr., Attorney, on this and to bring it up at the next Executive Committee meeting.

There being no further business the meeting was adjourned at 12:45 P.M.

MEDICAL SCHOOL COURSE COMMITTEE MEETING MINUTES

CHRIS J. McLOUGHLIN, Chairman of the Medical Association of Georgia Medical School Course Committee, called a meeting of the committee to order at 10:15 A.M., September 25, 1960 at the MAG Headquarters Office Building, 938 Peachtree Street, N.E., Atlanta, Georgia.

Members of the committee present included Chris J. McLoughlin, Atlanta, Chairman, and T. A. Sappington, Thomaston. Also in attendance were Arthur Richardson, Atlanta, Dean of Emory University School of Medicine; Harry O'Rear, Augusta, President of the Medical College of Georgia; Walter G. Rice, Augusta, Dean of the Medical College of Georgia; Mr. William Mankin, Atlanta, Mead Johnson Company, and Mr. M. D. Krueger, Atlanta, MAG Executive Secretary.

Chairman McLoughlin reviewed the past activity of the Medical School Course Committee and discussed in detail the lecture course title "Art of the Practice of Medicine," which was given at both the Medical College of Georgia and Emory University School of Medicine in past years. After general discussion, it was agreed that these courses of instruction be continued on a "non-compulsory" basis at both medical schools. It was recommended that advance data on the course be sent to the students and that the residents in the area also be invited to attend such courses. It was further recommended that the Mead Johnson material be incorporated in the lecture course at the committee's pleasure.

President O'Rear suggested that the actual scheduling of the lectures be discussed further with Dean Rice and suggested that six lectures be scheduled to run about an hour and a half each. Increasing the time for the lecture, would provide more opportunity for question and answer discussion of the topic.

Dean Arthur Richardson recommended that the individual scheduling and make-up of the lectures for the course be discussed further with Thomas Sellers, Jr.

A further recommendation of the committee members was to make available such a course of instruction for the residents and interns of approved hospitals over the state. It was believed that these hospitals could include such a course in their house training program.

There being no further business Chairman McLoughlin adjourned the meeting at 11:45 A.M.

BARBARA MILZ WINNER OF NATIONAL AWARD

MRS. BARBARA MILZ of Atlanta has won the nation's top award for newspaper reporting on heart and circulatory diseases.

The American Heart Association has announced that Mrs. Milz, a general assignment reporter for the *Atlanta Constitution*, has won a 1960 Howard Blakeslee Award. She is the only newspaper reporter in the nation so honored this year.

The award carries with it a citation and a honorarium of \$500. Winners in other categories included a physician-author, two free lance writers, a radio station, and a television station.

Mrs. Milz won her award for a six-part series she wrote in 1959 while a reporter for the *Augusta Chronicle-Herald*. The series described open heart surgery and the research advances which combined to make possible a successful heart operation.

The Blakeslee Awards were established eight years ago by the American Heart Association as a memorial to the late Howard W. Blakeslee, science editor of the Associated Press and a founder of the National Asso-

ciation of Science Writers, who died of heart disease.

Winners are selected for "creative efforts in any medium of mass communication which are judged to have contributed most to public understanding of progress in research and in the prevention, care, and treatment of a heart and circulatory diseases."

Mrs. Milz, a native of Walla Walla, Wash., has won other awards in Georgia this year. The Georgia Heart Association presented her with a Bronze Service award for the same heart series and also for her work in promoting the heart program in Richmond County.

She was named winner of the Class AA Chairman's prize for the Georgia Associated Press; first place winner in feature writing for the Georgia AP, and runner-up for the Georgia AP Sweepstakes Award.



Mrs. Barbara Milz

1960-61 CALENDAR OF MEETINGS

State

- Nov. 29-Dec. 1—"Fractures in General Practice," Medical College of Georgia, Augusta.
- Dec. 1-2—Postgraduate Course in Ophthalmic Surgery, Emory University School of Medicine, Grady Memorial Hospital, Atlanta.
- Dec. 6-8—"Workshop on Diabetes," Medical College of Georgia, Augusta.
- Dec. 10-11—MAG Conference for Presidents and Secretaries of County Medical Societies, Dinkler Plaza Hotel, Atlanta.
- Dec. 12-16—Basic Science Lecture sponsored by The Sisters of Mercy and the Medical Staff of St. Joseph's Infirmary, St. Joseph's Infirmary, Atlanta.
- Jan. 16-20—Basic Science Lecture sponsored by The Sisters of Mercy and the Medical Staff of St. Joseph's Infirmary, St. Joseph's Infirmary, Atlanta.
- Jan. 24-26—"Problems of the Newborn Infant," Medical College of Georgia, Augusta.
- Feb. 13-17—Basic Science Lecture sponsored by The Sisters of Mercy and the Medical Staff of St. Joseph's Infirmary, St. Joseph's Infirmary, Atlanta.
- Feb. 19-22—Atlanta Graduate Assembly, Biltmore Hotel, Atlanta.
- Feb. 28-Mar. 2—"Management of Your Patient with Vascular Disease," Medical College of Georgia, Augusta.
- Mar. 20-24—Basic Science Lecture sponsored by The Sisters of Mercy and the Medical Staff of St. Joseph's Infirmary, St. Joseph's Infirmary, Atlanta.

May 7-10—Annual Session, Medical Association of Georgia, Atlanta Biltmore Hotel, Atlanta.

Regional

- Dec. 6-8—Southern Surgical Association, Boca Raton Hotel, Boca Raton, Florida.
- Jan. 16-18—Sectional Meeting, American College of Surgeons, Hotel Dinkler-Tutwiler, Birmingham, Alabama.
- Mar. 6-9—Southeastern Surgical Congress, Deauville Hotel, Miami Beach, Florida.
- Apr. 9-12—Tennessee State Medical Association, Read House Hotel, Chattanooga, Tennessee.
- Apr. 22-25—Texas Medical Association, Galvez and Buccaneer Hotels, Galveston, Texas.

National

- Nov. 27—Second National Conference on the Medical Aspects of Sports, AMA, Statler Hilton Hotel, Washington, D. C.
- Nov. 28-Dec. 2—American Medical Association, Clinical Meeting, Washington, D. C.**
- Nov. 30—Symposium on Clinical Nutrition, Council on Foods and Nutrition of A.M.A. National Guard Armory, Washington, D. C.

- Nov. 30-Dec. 10—Tenth Medical Conference, Bahamas Conferences, Nassau, Bahamas.
- Dec. 1-2—Conference on Graduate Medical Education, "Educational Problems in the Internship and Residency," University of Pennsylvania Graduate School of Medicine, Philadelphia, Penn.
- Dec. 4-9—Radiological Society of North America, Netherland Hilton Hotel, Cincinnati, Ohio.
- Dec. 28-Jan. 7—Third Surgical Conference, Bahamas Conferences, Nassau, Bahamas.
- Jan. 8-13—American Academy of Orthopaedic Surgeons, Hotel Americana, Bal Harbour, Miami Beach, Florida.
- Jan. 8-14—Conference on Hypertension, Bahamas Conferences, Nassau, Bahamas.
- Jan. 9-13—Postgraduate Course in Recent Advances in Drug Therapy, American College of Physicians, University of Washington School of Medicine, Seattle, Washington.
- Jan. 9-14—Postgraduate Course in General Practice Review, University of Colorado Medical Center, Denver, Colorado.
- Jan. 12-14—Ninth Annual Cancer Seminar, Arizona Division of ACS, Tideland Motor Inn, Tucson, Arizona.
- Jan. 16-20—Postgraduate Course in Mechanisms of Disease, American College of Physicians, Columbia University College of Physicians and Surgeons, Presbyterian Hospital, New York, New York.
- Jan. 22-28—Third Serendipity Conference, Bahamas Conferences, Nassau, Bahamas.
- Jan. 23-25—The 25th Annual Session of the International Assembly of Southwest Texas, Granada Hotel, San Antonio, Texas.
- Jan. 26-28—Rocky Mountain Traumatic Surgical Society, The Aspen Meadows, Aspen, Colorado.
- Feb. 4-7—Congress on Medical Education and Licensure, Palmer House, Chicago, Illinois.
- Feb. 6-8—American Academy of Allergy, Statler-Hilton Hotel, Washington, D. C.
- Feb. 8-11—American College of Radiology, Drake Hotel, Chicago, Illinois.
- Feb. 9-15—Second Allergy Conference, Bahamas Conferences, Nassau, Bahamas.
- Feb. 20-24—Postgraduate Course in Selected Topics in Internal Medicine, American College of Physicians, University of Oklahoma School of Medicine and University Hospitals, Oklahoma City, Oklahoma.
- Mar. 20-24—Postgraduate Course in Medical Technology, University of Colorado Medical Center, Denver, Colorado.
- Mar. 20-24—American Surgical Association, Boca Raton Hotel, Boca Raton, Florida.

THE AMERICAN CANCER SOCIETY

is dedicated to saving lives from cancer and spearheads the fight against cancer quackery. Its Committee on New or Unproved Methods of Treatment of Cancer has a membership of physicians, lawyers, educators, and public relations specialists. This committee has been a prime mover in developing constructive action

against cancer quackery

Inspired by model legislation formulated by this committee with the active cooperation of the California Medical Association, California, Kentucky and Nevada recently passed bills providing the first effective means of fighting cancer quackery at its base of operations—in the local community.

To keep both the public and the medical profession informed, the Society has established, in its national office, a central repository of material on new or unproved methods of cancer diagnosis, treatment and cure—a principal source of such information in this country.

The American Cancer Society, in this as in all its efforts, serves both the private citizen and the practicing physician—and is, in turn, served by both.



THE AMERICAN CANCER SOCIETY

GEORGIA DIVISION

2025 Peachtree Rd., N. E.

Atlanta 5, Georgia

MEDICAL ASSOCIATION OF GEORGIA

STANDING COMMITTEES

Cancer

*Hoke Wammock, Augusta, *Chairman*
 *Everett L. Bishop, Atlanta
 *J. E. Scarborough, Atlanta
 David Henry Poer, Atlanta
 *R. C. Pendergrass, Americus
 Frank G. Stephens, Columbus
 John L. Barner, Athens
 F. G. Eldridge, Valdosta
 Lester Harbin, Rome
 *Thomas Harrold, Macon
 M. Fernan Nunez, Dublin
 Robert L. Brown, Atlanta
 *Neal F. Yeomans, Waycross
 Julian B. Neel, Thomasville
 Major F. Fowler, Atlanta
 Wadley R. Glenn, Atlanta
 *John T. Mauldin, Atlanta
 P. F. Brown, Jr., Gainesville
 *Enoch Callaway, LaGrange, *Ex-officio*
 (*Executive Committee)

Crawford W. Long Memorial

Lester Rumble, Jr., Atlanta, *Chairman* (1961)
 Perry P. Volpito, Augusta (1963)
 Calvin S. Allen, Gainesville (1962)

Constitution and Bylaws

Thomas W. Goodwin, Augusta, *Chairman* (1961)
 Alex P. Jones, Griffin (1963)
 T. Schley Gatewood, Americus (1962)

Geriatrics

Harry H. Brill, Jr., Columbus, *Chairman* (1961)
 Rudolph W. Jones, Jr., Macon (1963)
 Milton F. Bryant, Atlanta (1962)

History and Vital Statistics

Carl C. Aven, Marietta, *Chairman* (1963)
 Herbert S. Alden, Atlanta (1961)
 Morgan B. Raiford, Atlanta (1962)
 Edgar Woody, Jr., Atlanta, *Ex-officio*
 Paul T. Scoggins, Commerce, *Ex-officio*

Hospital Relations

David Henry Poer, Atlanta, *Chairman* (1963)
 Rafe Banks, Jr., Gainesville, *Vice Chairman* (1963)
 John L. Bowen, Sandy Springs (1963)
 F. G. Eldridge, Valdosta (1963)
 Herbert D. Tyler, Thomaston (1963)
 A. B. Conger, Columbus (1961)
 Robert B. Martin, Cuthbert (1961)
 James R. Paulk, Moultrie (1961)
 Walter E. Brown, Savannah (1961)
 W. L. Pomeroy, Waycross (1961)
 Henry H. Tift, Macon (1961)
 D. Lloyd Wood, Dalton (1962)
 John T. Mauldin, Atlanta (1962)
 Kirk Shepard, Thomasville (1962)
 A. W. Simpson, Jr., Washington (1962)
 Fred H. Simonton, Chickamauga (1962)
 P. W. Wurga, Athens (1962)
 Mr. James Sitton, Atlanta, *Ex-officio*

American Medical Education Foundation

A. B. Conger, Columbus, *Chairman*
 T. A. Sappington, Thomaston
 Harold M. Smith, Savannah
 James E. Bell, Augusta
 Jule C. Neal, Macon
 J. Hubert Milford, Hartwell

Blood Banks

G. Lester Forbes, Jr., Atlanta, *Chairman*
 Lee Howard, Jr., Savannah
 Walter L. Sheppard, Augusta
 Hamil Murray, Gainesville
 F. H. Thompson, Atlanta
 Frank L. Beckel, Columbus
 Leo A. Erbele, Macon

Crippled Children

J. C. Hughston, Columbus, *Chairman*
 F. James Funk, Jr., Atlanta
 John L. Chandler, Jr., Augusta
 H. M. Coe, Brunswick
 Robert Mabon, Atlanta
 James W. Bennett, Augusta
 W. G. Elliott, Cuthbert
 Ruth M. Waring, Savannah
 Atwood M. Freeman, Jr., Albany
 Ernest B. Dunlap, Jr., Atlanta

Industrial Health

T. A. Peterson, Savannah, *Chairman* (1963)
 Joseph M. Bosworth, Atlanta (1963)
 Alex P. Jones, Griffin (1961)
 George R. Conner, Columbus (1962)

Insurance and Economics

David R. Thomas, Jr., Augusta, *Chairman* (1961)
 Charles S. Jones, Atlanta, *Co-Chairman* (1962)
 John L. Elliott, Savannah (1963)
 W. P. Rhyne, Albany (1963)
 George Scheussler, Columbus (1963)
 Lester Harbin, Rome (1963)
 W. L. Pomeroy, Waycross (1962)
 H. H. Hammett, LaGrange (1962)
 Herbert M. Olnick, Macon (1961)
 Stewart G. Blackshear, Gainesville (1961)

Legislation

John A. Bell, Jr., Dublin, *Chairman* (1963)
 Eustace A. Allen, Atlanta, *Vice-Chairman* (1962)
 J. Frank Walker, Atlanta (1963)
 Virgil B. Williams, Griffin (1961)
 T. A. Peterson, Savannah (1961)
 Albert M. Deal, Statesboro (1962)

Maternal and Infant Welfare

Eugene L. Griffin, Atlanta, *Chairman* (1962)
 H. J. Bickerstaff, Columbus (1963)
 James W. Bennett, Augusta (1963)
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INFLUENZA FACT SHEET

SUPPLEMENT TO THE JOURNAL
OF THE MEDICAL ASSOCIATION OF
GEORGIA, DECEMBER 1960.

Background Information on the Need for Continuing Vaccination of High Risk Groups

PUBLIC HEALTH SERVICE U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE Communicable Disease Center

August 1, 1960

Introduction

For many years influenza has been recognized as a major recurrent cause of death. This was never more clearly demonstrated than in the catastrophic pandemic of 1918. Within the past three years, epidemic influenza has again been shown to be a major public health menace.

In the fall of 1957 and spring of 1958 an extensive epidemic of influenza occurred in the United States as well as the rest of the world. This was caused by a new antigenic variant of Type A influenza virus, subsequently termed Type A₂ or "Asian" influenza. This epidemic was associated with marked excess mortality particularly among older age groups and among those with associated chronic illness. During the first three months of 1960 another epidemic of Asian influenza occurred in the United States; excess mortality was again particularly evident among the aged and chronically ill. As was brought out at the International Conference on Asian Influenza, National Institutes of Health, February, 1960, analysis of the mortality associated with these epidemics has served to reemphasize the fact that individuals in age groups 65 years and over, and individuals with certain chronic diseases are at increased risk of death from influenza. Polyvalent, influenza virus vaccine, reevaluated within the past several years, has been shown to be of definite value in preventing influenza. Annual immunization of persons at high risk of death from influenza has been strongly recommended by the Public Health Service Advisory Committee on Influenza Research as a protective measure for this segment of the population. This FACT SHEET presents the background, rationale, and recommendations for carrying out routine immunization of these persons.

Mortality Due to Influenza - 1957-60

The United States has recently experienced three epidemic waves of Asian influenza. The first two waves appeared in the last quarter of 1957 and the first quarter of 1958 as a part of the world-wide pandemic; the third arose abruptly in the early winter months of 1960.

The lethal impact of an influenza epidemic is reflected not only in the excess mortality due to influenza and pneumonia and in the excess of deaths due to cardiovascular or renal disease, but a further reliable measure of an influenza epidemic is the total excess of observed deaths over the normal number of expected deaths during the same period. The calculations presented in the table show mortality in excess of seasonal expectancy after correction for population growth. The number of excess deaths are shown by age, and by selected causes during the three epidemic periods.

Estimated Excess Mortality by Age and Selected Causes
United States, 1957-58 and 1960^(1, 14)

Age Group	1957 Oct. -Dec.	1958 Jan. -Mar.	1960 Jan. -Mar.
Under 1	600	200	-3, 200*
1-14	1, 300	100	100
15-24	1, 000	300	200
25-44	3, 600	700	2, 200
45-64	10, 400	5, 300	6, 100
65 and over	22, 400	13, 400	21, 300
All Ages	39, 300	20, 000	26, 700
Selected Causes			
Pneumonia-Influenza	12, 100	6, 000	10, 600
Cardiovascular-renal	18, 700	13, 000	12, 200
All other causes	8, 500	1, 000	3, 900
Total	39, 300	20, 000	26, 700

* The infant mortality rate in January 1960 was the lowest rate ever recorded for January. Monthly Vital Statistics Report 9(3)2, May 18, 1960.

It may be seen that a total of almost 60,000 excess deaths was recorded in the six month period October-March 1957-58, with twice the excess mortality in the first as compared to the second wave. The 1960 epidemic contributed an excess of over 26,000 deaths. In each period, the population over 65 accounted for more than half of the number of excess deaths. During the first period, a relatively higher pro-

portion of younger age groups was included in the death toll, but in succeeding epidemics, the older age groups showed increasing proportions. In the most recent epidemic, over three-fourths of the total excess deaths occurred among older persons.

Of the excess deaths, nearly 85 percent were attributed to two categories: pneumonia-influenza (33 percent) and cardiovascular-renal diseases (51 percent). It is apparent that the population at highest risk are older persons, especially those who have suffered cardiovascular illness.

Because of the large number of excess deaths due to these recent outbreaks of influenza, the Public Health Service recommends a continuing effort to reduce this excess through the immunization of patients in selected groups known to have an increased risk of death from influenza.

Task for 1960 - Protection for the Aged and Chronically Ill

The Public Health Service Advisory Committee on Influenza Research has recommended that persons of all ages who have chronic cardiovascular, pulmonary, renal, or metabolic diseases, and pregnant women be immunized against influenza as a routine practice, since patients in these categories have experienced the highest mortality rates.

The specific recommendations of the Public Health Service for routine immunization include:

- A. Persons at all ages who suffer from chronic debilitating disease; e.g., cardiovascular, pulmonary, renal, or metabolic disorders; in particular -
 1. patients with rheumatic heart disease, especially those with mitral stenosis,
 2. patients with other cardiovascular disorders, such as arteriosclerotic or hypertensive heart disease; especially those with evidence of frank or incipient cardiac insufficiency,
 3. patients with chronic broncho-pulmonary disease; e.g., chronic asthma, chronic bronchitis, bronchiectasis, pulmonary fibrosis, pulmonary emphysema, and pulmonary tuberculosis,
 4. persons with diabetes mellitus, and
 5. patients with Addison's disease.

B. Pregnant women.

C. All persons 65 years and older.

Influenza may not be more likely to attack persons in these specified groups than others; the occurrence of influenza in these persons, however, is more likely to be a life-threatening event. Influenza alone places a severe stress on cardiovascular and pulmonary function, and the frequency of bacterial complications is greatly increased in patients with chronic cardiovascular-renal and pulmonary disease.

The Vaccine

Description. The commercial influenza vaccine is an aqueous, polyvalent, killed-virus preparation, with a prescribed antigenic composition for 1960 as follows:

<u>Type</u>	<u>Strain</u>	<u>CCA Units per cc.</u>
A	PR8	100
A ₁	Ann Arbor 1/57	100
A ₂	Asian	200
B	Great Lakes 1739/54	100

The total antigenic potency of the vaccine is 500 CCA units per cc.

Manufacturers. The following pharmaceutical houses are licensed manufacturers of influenza vaccine:

Eli Lilly and Company, Indianapolis, Indiana
Lederle Laboratories, Pearl River, New York
Merck, Sharpe, and Dohme, Philadelphia, Pennsylvania
National Drug Company, Philadelphia, Pennsylvania
Parke-Davis and Company, Detroit, Michigan
Charles Pfizer and Company, Brooklyn, New York
Pitman-Moore Company, Indianapolis, Indiana

Dosage. The recommended adult dose of polyvalent vaccine for the initial immunization is 1.0cc. (500 CCA units) subcutaneously, administered on two occasions separated by two or more months. Preferably the schedule of vaccination should be completed by November 1. Each fall thereafter, prior to November 1, persons in the groups specified to receive continuing protection and who have already had the initial immunizing series should receive a 1.0cc. booster dose of the vaccine subcutaneously.

Effectiveness. Numerous reports (2-10) of vaccine evaluations carried out within recent years have demonstrated that influenza vaccination may be expected to be from 60-75 per cent effective in preventing the disease.

Reactions. In adult populations, a low incidence of side reactions may be expected. These are most frequently in the form of transient febrile responses or local tenderness at the injection site. Penicillin sensitivity need not be of concern when injecting influenza vaccine, for current preparations contain none of this antibiotic. Since the vaccine is produced in eggs, the Advisory Committee has advised against vaccination for persons who are unable to eat eggs or chicken because of food allergy, or who have had a definite allergic reaction, whether urticarial, asthmatic, or anaphylactic, on previous inoculation of an egg vaccine.

Why a CONTINUING Vaccination Program Now for the Chronically Ill?

In the past, influenza immunization programs have tended to be intermittent, predominately in response to public concern before and during epidemic periods. Such epidemics tend to recur in cycles of unpredictable periodicity, but an endemic incidence occurs continually. For these reasons immunization of the specified high-risk groups is recommended to begin now and should be continued annually, regardless of the predicted incidence of influenza for a particular year.

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Cover:

The Communicable Disease Center, a National Division of the U. S. Public Health Service, was dedicated September 8, 1960. The Center is housed in six buildings, comprising a total area of 200,000 sq. ft. and is situated on a 15-acre tract near Emory University in Atlanta. This important facility, with its 700 workers, studies and makes recommendations for control of communicable diseases on a nation-wide basis. Cover drawing by Walter Dougherty.

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THE ROLE OF SURGERY IN CARCINOMA OF THE CERVIX

*This study represents a critical analysis of
sixty-six patients during the past ten years.*

Hoke Wammock, M.D., *Augusta*

THERE HAS BEEN MUCH progress in the past 50 years in our knowledge of the control of carcinoma of the cervix. The survival rate has been increased due to the improvement in radiation therapy technique and the application of surgical techniques.

In an effort to further increase the survival rate of invasive carcinoma of the cervix, the author has employed a combination of radiation therapy followed by a radical hysterectomy and bilateral iliac lymph node dissection. This is an analysis of 66 patients during the past 10 years, but this series is not large enough to be of statistical significance. However, the results present several points of interest that we need to consider.

Surgery as Adjunct to Radiation

There are others who have been interested in and have employed surgery as an adjunct to radiation in the treatment of carcinoma of the cervix. Weed¹ has reported on 79 cases of Wertheim hysterectomy and pelvic lymphadenectomy in a combination with radiation therapy preoperatively. His series is too small to be significant. Stevenson² and Bastiaanse³ have applied the principle of combined radiation therapy and radical surgery in stages I

and II carcinoma of the cervix, the latter with a salvage rate of 83 per cent. There is a trend at the present time in some clinics to employ surgery as an adjunct to radiation therapy.

The long-accepted principle of treatment of carcinoma of the cervix was that of radiation until 1939, when Meigs⁴ began to perform the Wertheim procedure and added to this a routine dissection of the pelvic lymph nodes in carcinoma of the cervix, stages I and II, with a report of five-year survival of 74.1 per cent of cases in stage I. These figures compare with stage I cases receiving radiation therapy on the collective view of 66 per cent to 88 per cent, as reported by Nickson.⁵ In stage II, the five-year survival rate is reported as 50 per cent to 58 per cent.

However, with either one of these methods of therapy, there are 20 per cent to 25 per cent of patients with stage I carcinoma who succumb to the disease, and of those with stage II carcinoma, about 50 per cent succumb to the disease.

The annual report of the results of radiation therapy of carcinoma of the cervix from Stockholm⁶ reveals the following figures for a five-year survival rate for the four stages of carcinoma of the cervix, according to the League of Nations classification, based on a total of 7,675 patients treated with radiation: Stage I—62.5 per cent, Stage II—46.8 per cent, Stage III—24.7 per cent, Stage IV—5.1 per cent. These cases, of course, represent great variation among different clinics with respect to the

Dr. Wammock is Professor and Chairman of the Department of Oncology, Medical College of Georgia, Augusta.

Presented at the 106th Annual Session of the Medical Association of Georgia, May 3, 1960, Columbus, Georgia.

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CARCINOMA OF CERVIX / Wammock

number of patients examined and the number of patients actually treated.

A further effort to salvage a greater number of cases has been the work of Brunschwig,^{7,8} who employed surgery in carcinoma of the cervix resistant to radiation. He later began to apply this principle to patients with untreated carcinoma of the cervix. Recently he has reported on 149 cases of stage I carcinoma of the cervix with an 83 per cent five-year survival rate, and a 19 per cent five-year survival rate for stage IV.

Other Studies on Radiation Therapy

Other efforts have been made to understand the nature of this disease and its response to radiation therapy by Graham and Graham.⁹ They have studied the vaginal smears on patients receiving radiation therapy to determine the sensitivity response of the tumor cells to radiation. Patients with cancer of the cervix have basal cells with dense basophilic, finely vacuolated cytoplasm in the vaginal smear before treatment. These cells come from the parabasal cell area of non-malignant squamous epithelium of the cervix and the vagina. When 10 per cent or more of these cells are present, the patient usually responds to radiation. This is known as the SR factor. If less than 10 per cent are present, they respond better to surgery. Furthermore, they have examined the smears of 635 patients with carcinoma of the cervix¹⁰ and found that the greater the number of malignant cells, the greater the percentage of lymph nodal involvement, and the poorer the results. We have not employed this method of determining resistance to radiation.

Friedel¹¹ has just reported on the spread of cervical cancer as seen in the whole histological section. Direct extension in perineural spaces was the most prominent mode of spread. However, the involved lymph nodes were relatively infrequent. The cancer spreads to the paracervical and paravaginal tissues and usually extends more in the anterior and the posterior than in the lateral direction. Thus, if cancer is to be controlled, it is necessary to remove lymph nodes and a large cuff of vaginal tissue. This is one of the reasons why simple hysterectomy is of no value. Meigs⁴ has reported that nodes were involved in 17.5 per cent of cases in stage I and in 32 per cent of cases in stage II.

Points for Consideration

There are a number of points for consideration when one is planning therapy, whether to use radi-

ation alone, surgery alone, or a combination of radiation and surgery. They are as follows:

- I. the sensitivity of the tumor to radiation,
- II. stage of disease,
- III. residual disease in cervix after radiation,
- IV. recurrent disease in vaginal stump after surgery alone,
- V. metastatic spread to lymph nodes, and
- VI. clinical condition of the patient.

Our plan of therapy in invasive carcinoma of the cervix is to administer 6,000 to 8,000 gamma roentgens to the tumor-bearing area by proper application of radium intra-uterinely and intravaginally. We prefer not to use deep therapy. This is followed by radical hysterectomy and includes a bilateral iliac lymph node dissection within a period of four weeks. This is preferable in order to avoid fixation of tissues and provides greater ease of dissection of the connective tissue planes. Otherwise, if one waits for some period of eight to 12 weeks or more, the pelvic structures become more fibrotic and fixed in their position and the technic becomes more difficult. I do not believe it is a good plan to wait and see what will happen, as far as possible local recurrence or metastatic involvement is concerned, particularly in stages I and II after administering radiation therapy. I, therefore, believe that patients should be given the benefit of a radical type of surgery, an iliac lymph node dissection following radiation within a period of four weeks. The question may be raised as to whether or not a biopsy should be performed after the completion of the radiation therapy to determine if there is residual disease. In the event that a biopsy is performed and is negative, this still does not answer the question as to the possibility of metastasis to the pelvic lymph nodes.

Morbidity and Mortality Rise As Disease Progresses

As the disease progresses and a second attempt is made to salvage the case either by the administration of further radiation or the utilization of surgery, the morbidity and the mortality, of course, begin to rise. Furthermore, patients who have had some previous type of surgery, such as a supercervical hysterectomy, and have developed carcinoma of the cervix at a later date, are not necessarily lost. A few of them may be salvaged. A patient who has had residual disease after radiation therapy should be considered for exploration to determine the feasibility of resectability.

Some patients with early invasive carcinoma of the cervix treated with radiation do have residual disease and they also may have metastatic disease.

In this discussion we are not deploring the administration of radiation therapy as a primary therapeutic procedure in stage I; neither are we deploring the administration of surgery as a primary therapeutic procedure in the treatment of stage I carcinoma of the cervix. However, we are employing the two methods as a complementary procedure.

Our report deals with an analysis of 66 patients with stages I, II, III, and IV carcinoma of the cervix. In some we initiated the therapy, while others had received some form of therapy elsewhere. There was only one death. This was in a patient with advancing disease treated elsewhere by radiation.

Stage I Carcinoma of Cervix

There were 14 patients with stage I carcinoma of the cervix. Eleven of these were treated with radium followed by radical hysterectomy and iliac lymph node dissection. They are living and well for over two years. Two patients had residual disease, one of these also having metastasis to a lymph node. One patient had a radical hysterectomy and node dissection and was found to have metastasis to the fallopian tube. Two patients had carcinoma of the cervical stump, one of which was treated by radium and is living and well after 10 years, and the other treated by hysterectomy only and is living seven years. In this group there were no fistulae as a result of the surgery.

Stage II Carcinoma of Cervix

There were 16 patients with stage II carcinoma of the cervix, all of whom received radiation therapy. Twelve were treated with radical hysterectomy and bilateral iliac lymph node dissection. Of these 12, 11 are living and well, six of these over five years. Two of the remaining four patients had a total hysterectomy and died with the disease. One patient was explored with the idea of performing a radical procedure, but she was thought to be inoperable and is still living after six years. The other patient had a pelvic exenteration and died from metastatic disease. There was one patient in this group who had a vesicovaginal fistula. This was closed and she is doing very well. Six of these 16 patients had residual disease. Three of these are living and well over five years. One patient had metastasis to the ovary, one metastasis to the lymph nodes, and one patient died with metastasis to the lung after a period of six years. The latter had residual disease in the cervical and vaginal stump.

There were 13 patients with stage III carcinoma of the cervix. They were treated with x-ray and radium. Four of these patients were not operated upon be-

cause of poor condition. Seven were treated by radical hysterectomy and iliac lymph node dissection, and two patients were explored, but disease was too extensive for surgery. Of these 13 patients, two are living and well, five and eight years respectively. The remaining patients developed recurrence or metastasis.

Patients with Primary Treatment Elsewhere

There are 15 patients that make up the group who had some form of primary treatment elsewhere. Six of these had a hysterectomy prior to coming to me. Of these six, four are living and well for six, 11, five, and two years. The other two patients died. A pelvic resection was performed on four of these with excision of the vaginal stump, and of these four only one showed residual disease. Seven of the 15 patients had some form of radiation therapy elsewhere. One patient had a radical hysterectomy and iliac lymph node dissection. She had residual disease but no evidence of metastasis. She is living and well after six years and has a small vesicovaginal fistula. Four patients had a pelvic exenteration. One of these had an anterior type of exenteration and transplantation of the ureters into the rectum. She had residual disease and is living and well after five years. One had anterior exenteration with transplantation of the ureters into the rectal pouch. She had residual disease of the vagina and died of metastasis. One had a supracervical hysterectomy many years ago for carcinoma of the cervical stump. She was treated by radium elsewhere, and had radical type of hysterectomy and iliac lymph node dissection later, followed by an ileal bladder. She died of recurrence and metastasis. This patient was urged to be operated upon many years before she submitted to surgery. The fourth patient, who had pelvic exenteration, died of hemorrhage. There was extensive disease to the pelvic floor and she should not have had the operation. The four remaining patients in this group had radiation therapy elsewhere and were explored and found to be inoperable. There were two patients in this group to develop a vesicovaginal fistula. One of these had had a total abdominal hysterectomy and the line of margin was through tumor. She was reoperated upon and had a bilateral iliac lymph node dissection and removal of the vaginal stump. The fistula has been closed and she is now free of disease. The second patient with a vesicovaginal fistula had primary radiation therapy elsewhere and we then performed a radical procedure. She developed a vesicovaginal fistula but is still free of disease.

There were eight cases of stage IV carcinoma of the cervix. These were far advanced, although one

CARCINOMA OF CERVIX / Wammock

was advised to have an exploratory procedure and refused.

There were four cases of pre-invasive carcinoma of the cervix, not included in this study. These patients had a radical hysterectomy of the Wertheim type, but did not have a lymph node dissection. All of these patients are living and have had no sign of recurrence or metastasis.

Review of Cases

A review of these cases reveals that there was no postoperative mortality in 43 patients receiving primary radiation therapy followed by surgery of the radical type. The morbidity has been relatively low. Three patients developed a vesicovaginal fistula postoperatively. One of these was in a patient who had had a total hysterectomy and the surgical margin cut through the tumor-bearing area. This patient was recommitted to a radical type of surgery, performing a bilateral iliac lymph node dissection and removal of the vaginal stump. The other patient, who had a large exophytic lesion of the cervix, developed a vesicovaginal fistula which was treated by cautery. She had had radium followed by a radical type of hysterectomy with a bilateral iliac lymph node dissection.

The third patient, who developed a vesicovaginal fistula, had received her radiation therapy elsewhere. This consisted of deep therapy and the application of radium to the cervix. This patient had residual disease. She is now living and well five years and has had no sign of recurrence or metastasis.

The question may be rightfully asked: if 75 per cent of the patients with stage I carcinoma of the cervix can be cured with radiation therapy or with radical surgery alone, why subject these patients to a double procedure? The object of the therapy is to annihilate the disease in all patients, if possible. We have not employed cytological study of the cells preoperatively and during radiation to determine their sensitivity to radiation. Neither do we advocate taking a biopsy of the cervix after the radiation to determine if there is residual disease. There is a perfectly good reason for this. It is that if a biopsy is taken and is reported as negative, one may be too complacent, and assume that there is no residual or metastatic disease. Therefore, the exploratory procedure is advantageous in determining the question of metastatic disease.

There are also other indications for the utilization of both procedures. It becomes increasingly difficult at times to decide whether a case is a late stage I or an early stage II carcinoma of the cervix. This being the case, if it should turn out to be a stage

II, the survival rate drops and the metastatic potential increases.

In planning this type of therapy, a combination of radiation and surgery, one must inquire of the morbidity that may result under these conditions. I would like to point out that in patients in whom we planned and administered both radiation and surgery there were no ureteral nor vesicovaginal fistulae, nor was there any mortality rate. The patients who received radiation elsewhere were more than likely to develop some type of complication because of the interval of time between the radiation therapy and the surgical procedure. This is one of the reasons why we stress the importance of planning of the therapy so as to eradicate the disease with a minimal risk of morbidity and mortality.

Author's Strategy

It is the author's opinion that every patient with carcinoma of the cervix should be thoroughly and adequately surveyed and that the following strategy be mapped out: (1) classify the disease; (2) determine the degree of histological activity, and (3) plan the therapy, whether it be radiation or surgery. In stages I and II we advocate the use of radium therapy alone with no external radiation. In stages III and IV we advocate, in addition to radium, deep therapy x-ray. We prefer surgery be employed within a period of four weeks of the completion of the radiation therapy.

Conclusions

What we are endeavoring to do with radiation is to control the disease around the cervix and destroy viable cells that may be present during the time of the surgical procedure. The surgical procedure will take care of the metastatic nodal involvement, and if the surgery is performed within this period of time after the application of radiation, the technical procedure is much easier and the tissues tease away without difficulty. If one waits until the third or the fourth month or longer, the structures become fixed to the lateral wall of the pelvis and makes the procedure difficult and increases the hazard of ureteral and vesicle fistula.

We feel that this work should be studied further in order to select proper therapy with minimal risk to the patient.

Medical College of Georgia

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NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
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Thrash, Calvin L., Jr.	3619 Calvin Dr. Columbus	Active	Muscogee

PULMONARY DISEASE AND COTTON PROCESSING

Harry E. Dickson, M.D. and Ross L. McLean, M.D., *Atlanta*

Pulmonary fibrosis is not characteristic of the disease nor are there usually chest x-ray findings compatible with a pneumoconiosis.

FOR ABOUT 100 YEARS, cotton mill workers in England have been known to suffer a chronic respiratory disease associated with the inhalation of cotton dust.¹ This disease is called byssinosis and is characterized in its early stages by a history of chest tightness and breathlessness on the first day of exposure to dust after an absence from work. The symptoms may progress into more chronic states of bronchitis and emphysema. Cough, productive of a tenacious sputum, is usually present in the more advanced cases. Pulmonary fibrosis is not characteristic of the disease nor are there usually chest x-ray findings compatible with a pneumoconiosis. The characteristic symptomatology together with a history of exposure to cotton mill dust over a period of one or two decades can, with reservations, be diagnosed as byssinosis.

Epidemiological Analysis

There are 175 textile mills in Georgia employing about 100,000 individuals. Georgia ranks third in the manufacture of cotton textiles, utilizing one and a half to two million bales of cotton annually with a gross value of one billion dollars derived from this industry. Many of these 175 mills have ultra modern ventilation equipment and techniques designed to reduce the hazard of dust. Others, for reasons of economy, size, etc., may not have adequate ventilation.

Is there an increased incidence of pulmonary disease in American mill workers engaged in the processing of cotton? Is there a direct relationship between prolonged exposure to high concentrations

of cotton dusts and pulmonary disease in the textile industries of Georgia? A survey of the literature reveals that no studies of this nature have been reported in this state. What, then, do the studies that have been performed elsewhere reveal relative to pulmonary disease and cotton processing?

Survey of the Foreign Literature

Byssinosis has been found to occur commonly among card room and blow room workers in the cotton mills of Lancashire, England. Dr. R. S. F. Schilling, Chief, Department of Occupational Health, London School of Hygiene and Tropical Medicine, in his Milroy Lectures (delivered before the Royal College of Physicians of London on February 7 and 9, 1956),² reviewed the results of several years study of the health and working conditions of cotton mill workers in Lancashire. Utilizing meticulous techniques of epidemiologic investigation, which have yielded a high level of inherent consistency, he found symptoms of byssinosis in 61 per cent of 190 card room and blow room workers, 40-59 years of age. Fourteen per cent were seriously disabled. The prevalence was found to be closely related to the total dust count. He concluded that "Byssinosis is now a serious problem in the Lancashire cotton industry." After pointing out that the disease must be diagnosed solely on the patient's history, that the late stages of byssinosis are indistinguishable from advanced chronic bronchitis and emphysema, and that there is no characteristic x-ray picture, he went on to say, "It is not surprising that it has been overlooked in this age of medicine in which doctors have so little time for history taking and hesitate to make a diagnosis without the aid of the laboratory and the radiologist."

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Dr. McLean is Associate Professor, Department of Medicine, Emory University School of Medicine, Atlanta.

Physiologic tests by McKerrow³ and his colleagues have supported and extended Schilling's epidemiologic studies by demonstrating a nearly linear decline in the pulmonary ventilatory capacity of card room workers during the day's work. The change occurs in some who have no symptoms of byssinosis, but with proportionately greater frequency and degree in those with symptoms. This change is confirmed by a parallel increase in air way resistance which can be relieved by adrenalin but not by antihistaminics. The specificity of this change for cotton dust has been demonstrated by the fact that both the acute symptoms and the physiologic changes which occur during the working day are eliminated by (1) removal of the subject from exposure (although chronic symptoms and disability in advanced cases usually persist); (2) failure to reproduce the symptoms or the physiologic changes upon exposing the same workers to high concentrations of coal dust; (3) duplication of acute symptoms and physiologic findings upon re-exposure of the same workers to cotton mill dust; (4) securing marked acute symptoms and physiologic changes upon the exposure of normal volunteers to card room dust, and (5) securing the same physiologic changes in normal volunteers inhaling an aqueous extract of cotton mill dust.

Thus, the presence of a symptom complex known as byssinosis has been convincingly demonstrated by excellent epidemiologic studies in England. That it is a measurable physiologic response to a pharmacologically active component of cotton mill dust has also been clearly shown. Other European investigators, particularly in Holland and Belgium, have confirmed these findings and cooperative international studies are now underway to compare etiology, prevalence, and methods of control.

For the present, Schilling⁴ has proposed a permissible dust level of 250 mg/100m³. At this level, the incidence of byssinosis is very low and periodic examinations of exposed workers can then reveal the susceptibles and permit their removal from exposure before serious damage has occurred.

A Survey of American Literature

Several small studies pertaining to byssinosis have been conducted in the United States, but with inconclusive results.

In 1945, Ritter and Nussbaum,⁵ in Mississippi, performed physical examinations and chest x-rays on 26 employees who had been exposed to cotton dust in excess of 20 years. None had complaints or physical findings relating to the respiratory system, the report states. It is pertinent to note here, however, that these reports do not indicate that detailed pulmonary function studies were carried out, nor was

there any effort to correlate weighted lifetime dust exposures with these cases. The same is true of all the United States studies to be found in the literature to date.

Considerable work has been done relative to the allergins in and histamine reactions of cotton dust, as well as the bacteria and molds present on low grade stained cotton as possible causes of "mill fever" or "Monday fever" in textile workers. Neal, Schneider, and Caminita⁶ investigated samples of cotton lint in rural mattress projects and found a gram negative, rod-shaped bacteria which was assumed to have caused the acute illnesses reported in these workers.

In a report of 1938 from the Director of North Carolina Division of Industrial Hygiene, in a table representing data on respiratory disease mortality according to occupation, it is shown for males aged 20-65 years in certain non-silicious dusty occupations, the incidence of bronchitis among cotton strippers is from three to 10 times greater than for other occupations listed. In this report, in the course of a description of the effects of exposure to cotton dust, is the statement: "They lost flesh, became thin in face and body. There was little tuberculosis, but the death rates from pneumonia were high."

Of 88 textile workers studied by Bloomfield, et al,⁷ in a Southern textile mill, and reported in 1933, none were classified as having "more fibrosis than usual" without dormant or healed tuberculosis. The results of the study are to be regarded as essentially negative, the report states.

Bolen⁸ in 1943, reports in detail on two cases of byssinosis occurring in textile workers in Massachusetts. Both men had been employed for many years in the card room of a textile plant. The main criterion for arriving at the diagnosis of byssinosis was the long term of service in the mill.

Discussion

The failure to recognize cotton dust disease of the lungs in this country may not necessarily reflect its true absence, as claimed by many, for several reasons:

(1) The symptom complex is not well known and it is not generally appreciated that the diagnosis does not depend on x-ray findings, but rather upon the characteristic symptomatology coupled with a compatible occupational history.

(2) The well-known complex of chronic bronchitis and progressive obstructive emphysema with peribronchial fibrosis by x-ray, which is sometimes looked upon as the result of cotton dust exposure in certain individuals who have worked many years in mills, is indistinguishable from the chronic bronchitis and emphysema which is encountered in non-

exposed individuals. In other words, the late stages of byssinosis are indistinguishable from the advanced stages of chronic bronchitis and emphysema.

(3) Epidemiologic surveys comparable to those of Schilling and his colleagues, which were so beautifully designed and meticulously executed, have not been attempted in this country. Highly trained investigators working within a rigid framework of a closely controlled epidemiologic study can secure evidence based upon symptoms and occupational histories alone which are amenable to strict statistical analysis for level of significance. None of the studies thus far reported in this country can meet these requirements. Until such time as epidemiologic studies of comparable or equivalent design have been applied in this country, a valid basis for the comparison of cotton dust disease incidence in the mills of this country with that in Great Britain is not available. There may be every reason to suspect that the incidence of this disease is far lower in this country than elsewhere in the world, but the objective demonstration of this suspicion is yet to be made.

There are two objective techniques which have demonstrated that the symptom complex of byssinosis is more than a professional evaluation of subjective sensations experienced under conditions of dust exposure. The first of these is the demonstration of a pharmacologically active substance present in cotton mill dust which has been found to reproduce the impaired ventilatory capacity of the workers with byssinosis when inhaled by normal volunteers. The second is the demonstration of progressive physiologic impairment during the course of the working day which is regularly and reliably more pronounced in patients with the more advanced stages of byssinosis. This reaction could be eliminated by removing workers from exposure and could not be reproduced by exposing these same workers to other forms of dust. In addition, normal volunteers exposed to the dust of the card room have demonstrated, although in a much more acute form, these same physiologic responses, which, again, are eliminated by removal from exposure.

The link between the symptom complex of byssinosis in its earliest stages and the marked dis-

ability of the later stages, in which the clinical and physiologic picture is one of chronic bronchitis and emphysema, is seemingly evident, but has not been conclusively demonstrated. Only well controlled horizontal studies will add further to this point. It would appear that the lack of such studies in this country deprives us of a sound basis for predicting the actual probability of cotton dust exposure giving rise to permanent impairment of health in the later years of life.

Summary and Conclusions

1. Byssinosis has been described in the cotton mill workers of Lancashire and is characterized in its early stages by a history of chest tightness and breathlessness on the first day of exposure to dust after an absence from work. The symptoms may progress into more chronic states of bronchitis and emphysema.

2. Byssinosis is apparently a physiologic reaction of the tracheobronchial tree to a pharmacologically active component of cotton mill dust.

3. The prevalence of byssinosis in this country is unknown due to the lack of suitable studies.

4. The relationship between the early symptoms of byssinosis and the late stages of irreversible loss of pulmonary function should be determined.

47 Trinity Avenue

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MYASTHENIA GRAVIS

Staff of the Medical College of Georgia, *Augusta*

Moderator: Dr. Zerman will present the case this morning.

Dr. Zerman: The case this morning is one of myasthenia gravis. We thought we had a therapeutic achievement to present, but things went bad just this morning. This 28-year-old colored male was in good health until November of 1959, when he rather abruptly one day noted weakness and increased effort in walking and shortening of his gait. Later the same day, he noted difficulty in chewing and swallowing his food. He continued at work for several days despite generalized weakness. He felt somewhat better and stronger in the morning with progressive weakness later in the day, this becoming profound by mid-afternoon. About a week after the onset, he was referred to Dr. Ernest Daniels who diagnosed myasthenia gravis, and started him on neostigmine 45 mg. every three hours around the clock. The medicine seemed to help but he continued to feel weak and needed help getting in bed at night. At times, despite the medication, he had difficulty in swallowing and in keeping his eyes open. There was some diplopia. Whenever he would eat or drink too rapidly, the food would regurgitate through his nose. Because of lack of funds, he ran out of neostigmine and he arrived here having had only 30 mg. in the previous ten hours.

Physical examination showed him to look very ill; he was profoundly weak, and it required a great deal of effort for him to speak. He was extremely apprehensive and restless. He was unable to lift his head from the pillow and there was ptosis of both eyelids with fixation of the eyes straight ahead.

Improvement was dramatic in a minute or so

subsequent to a Tensilon® test. We gave him 5 mg. intravenously and he sat up without assistance for several minutes afterwards. This was considered a positive test. The intercostal muscles showed no activity, respiration being abdominal in type. Otherwise the examination was not remarkable.

Soon after admission neostigmine was discontinued and Mestinon® begun, a total of 1080 mg. daily in divided doses. It soon became evident he would require alteration in dosages because of weakness in the late afternoons. A good many changes in both the time schedule and the doses were made based on the clinical response. He was checked periodically with Tensilon® because of complaints of weakness, usually in the late afternoon, and these tests were always positive. Finally, he was maintained at a dosage level of 1620 mg. a day. Up until this morning the schedule was 7:00 A.M.—300 mg., at 10:00 A.M.—240 mg., at 12 Noon—120 mg., at 3:00 P.M.—300mg., at 6:00 P.M.—300 mg., at 9:00 P.M.—180 mg., and at 10:00 P.M. a time spansule of 180 mg. With this schedule he was doing as well as we might expect and we had even planned to let him go, as soon as some money could be obtained to pay for his Mestinon.® (His medications cost about \$40.00 a month.) This morning, rather suddenly, about one half hour after his first dose of Mestinon,® he developed severe difficulty in breathing and began accumulating secretions in his pharynx and trachea. Tracheal suction removed large quantities of mucus. He was given a test dose of Tensilon® of 10 mg. with questionable transitory improvement. He seemed a little more responsive but then after about two minutes he became very weak again. A tracheostomy had to be done after he went into respiratory collapse. He was bag breathed and oxygen was administered. To help reduce the secretions he was given 0.4 mg. atropine. After tracheostomy was concluded he was taken to the respiratory ward and placed in a tank respirator. We have a progress report that he is breathing

Therapeutic Conference is a weekly presentation of the Departments of Pharmacology, Medicine, Surgery, and Pediatrics. This article is an edited verbatim transcription of a conference presented in the spring of 1960. The participants were: R. P. Ahlquist, Ph.D., Professor and Chairman of Pharmacology, Moderator; John Kemble, M.D., Professor of Neurology; Dorothy Hahn, M.D., Assistant Medical Director Regional Respiratory Center; Enon C. Hopkins, M.D., Assistant Professor of Medicine; Joseph P. Bailey, M.D., Resident in Medicine; Joseph L. Zerman, M.D., Intern in Medicine, and Antonio Fernandez, third year medical student.

MYASTHENIA GRAVIS / Therapeutic Conference

a little better now, and has been out of the respirator and breathing alone for an hour. The quinacrine listed in the protocol was given for *Giardia lamblia* in the stool.

Dr. Ahlquist: There are a number of interesting points that obviously come out of this case. First, we should review briefly the pharmacology of these drugs that are useful in the treatment of myasthenia gravis. Second, we should hear something about the interpretation of this Tensilon® test in diagnosing the disease and also in following the progress of the patient on treatment with these substances. I might report at first, just briefly, that this disease is becoming popular again in the experimental fields. For a long time pharmacologists or clinicians really did little with it except to try to find new drugs. At the University of Pittsburgh, a study to determine the distribution of acetylcholine esterase in muscle has been started. They have studied a number of normals and have located the cell fraction in muscle in which the acetylcholine esterase is located, apparently the mitochondria. At the time this report was given, they had tested the muscle from one case of myasthenia gravis. This muscle was obtained post mortem, unfortunately, and they were unable to really tell the status of the patient as to how many drugs he had had and at what time. Although they did find a very low acetylcholine esterase value in this muscle, they could not draw any conclusions from this one case. I am sure in the near future the localization of this enzyme in the muscle in myasthenia gravis will receive much more attention. Let's ask Mr. Fernandez to briefly review the principle pharmacology of these drugs: pyridostigmine (Mestinon®), neostigmine (Prostigmine®), and edrophonium chloride (Tensilon®).

Mr. Fernandez: These drugs belong to the group of drugs which are known as the cholinesterase inhibitors. Acetylcholine, when it is produced, is thereafter rapidly hydrolyzed by cholinesterase. The basic defect in myasthenia gravis is at the neuromuscular junction. It is felt that perhaps there just is not enough acetylcholine present and by increasing the acetylcholine we can get away from this muscular weakness. By giving one of the cholinesterase inhibitors, which prevents this hydrolysis of acetylcholine, we thereby increase the amount of acetylcholine at the myoneural junction and thus its effects are made known.

Dr. Ahlquist: What is the difference between these three?

Mr. Fernandez: Qualitatively there is no difference. The difference is mainly that of duration of

action and onset of action. I think the neostigmine, which is the basic drug first used, has a comparatively long duration of onset and its length of action is short. Mestinon®, the drug he is now on, is a more rapidly acting drug and its duration is also longer. Tensilon® is the most rapidly acting of the three drugs. Its action is manifested usually within one to five minutes with intravenous injection and is usually gone in approximately 30 minutes. I might comment that in these three drugs the action is all reversible. They hook up with the cholinesterase, but once this bond is broken the cholinesterases are again present to hydrolyze acetylcholine. There are some inhibitors; for example, diisopropyl fluorophosphate, which are irreversible cholinesterase inhibitors and when they are given, the duration of action is somewhere up into weeks. You have to wait for an entirely new supply of cholinesterase to be produced again.

Dr. Ahlquist: Why isn't DFP (isofluorophate) used in these patients? It sounds like the ideal drug to me.

Mr. Fernandez: Perhaps so, but if you increase the amount of acetylcholine at the myoneural junction to some great amount, then a new problem develops. Acetylcholine is necessary for the depolarization of this muscle and, therefore, you get contraction. But if the acetylcholine continues to remain at the site, you will never get repolarization of the muscle and so a constant state of paralysis. Therefore, you couldn't very well use one of these drugs.

Dr. Ahlquist: I think that point can be easily argued, for when the Tensilon® is given, you inhibit the cholinesterase to a maximum and yet with the usual dose you don't end up with paralysis. Now obviously, as Mr. Fernandez stated, you can carry this thing too far. If the acetylcholine is allowed to attach itself permanently to the receptors, the receptor can no longer respond and the patient does become paralyzed, but now for a different reason. Now we should ask Dr. Kemble to interpret the Tensilon® test for us, and also to give us a statement as to how often and how frequently paralysis due to overdose of these substances occurs.

Dr. Kemble: I think from the descriptions of the Tensilon® test that I heard this morning that it can be interpreted. Unless the Tensilon® test is clearly and strongly positive, it should be regarded as not indicating a myasthenic state; that is, not if there is a question about it. The greatest number of people that I talked to indicated that there was some doubt about this having any marked strengthening effect. It is quite different from that described on admission at which time Dr. Bailey and Dr. Zerman gave him the usual test dose of Tensilon® and he sat up in bed and was able to talk without difficulty

for two or three minutes. How often does this situation arise? It was of interest to look at the occurrence of this at the Mount Sinai Hospital in one series, but quite a sizeable series as myasthenic patients go. Dr. Osserman described 57 patients in whom 67 crises occurred. Of these, 47 were determined to be myasthenic crises, 20 were cholinergic. Some of these were mixed, showing features of both cholinergic and myasthenic crises. Fifty-one of these patients had to be treated in a respirator and 31 had to have a tracheostomy done.

Dr. Bailey: What do you think the patient's difficulty was this morning?

Dr. Kemble: I believe it was likely to have been a cholinergic crisis, partly on the basis of the indeterminate nature of the Tensilon® test; in other words, without strong improvement and partly the fact that it occurred some 40 minutes after the medication was given at 7:00 A.M. Now, as to why this should suddenly occur on a dosage that had been given to this patient for about a month, I don't know. As far as we know, he is not febrile and hasn't been up to this morning. He does not have evidence for an upper respiratory infection. Myasthenic crises have occurred in the face of emotional disturbances, but not cholinergic crises. Myasthenic respiratory failure has occurred in episodes of emotional trauma to myasthenic patients. This is something that might be gone into; that is, what took place with this patient and his visitors yesterday afternoon. The attending physicians on the floor thought that after the visitors left he was unduly depressed for some reason. When it becomes difficult to determine which type of crisis you are dealing with, I think the maneuver should be as was done this morning. Immediately get respiratory aid and endeavor to settle this question later. When he is in the respirator, stop the specific medication for at least 24 hours, probably longer, and see what happens. I certainly would like to hear Dr. Hahn's comments, because she says he is now breathing without aid of the respirator and this may be a transient affair. If this is now the state where some of the excess drug has been now removed, perhaps he is now getting its beneficial effect and within the next four or five hours we will see weakness due to the myasthenia appear. It will be interesting to see later this afternoon whether this takes place.

Dr. Hopkins: Could this occurrence take place as a result of a remission of the severity of this man's myasthenia?

Dr. Kemble: Yes, it is so reported. I have never had this occur, that I recognized, but it is reported that if the disease, let us say, becomes less severe, then he could have a cholinergic reaction or crisis

with the same level of the medication. I doubt that this is what has taken place. I may be completely wrong and this might have been a myasthenic crisis.

Dr. Ahlquist: Since the obvious treatment for non-breathing is a respirator, we might ask Dr. Hahn to comment and find out whether she approves of this tracheostomy and bag breathing with oxygen, rather than carrying the patient to the respirator immediately or bringing a respirator to the patient. Perhaps she will fill us in briefly on the role of mechanically aided respiration in a disorder such as this.

Dr. Hahn: I did not see this patient this morning at the onset of his difficulty, but I believe that the proper sequence of events was effected. The tracheotomy in a patient with myasthenia in a respirator is almost essential. I am surprised that such patients have been in a tank respirator without tracheostomy having been done. The reason for this is the difficulty in swallowing. This man is still having definite difficulty in swallowing his secretions. He is expectorating almost continuously so that a tracheostomy is essential. This enables us to give him artificial respiration with almost any type of respiratory equipment. The ambulatory type of hand bellows was used to ventilate the patient in transit from fifth to seventh floor and worked quite satisfactorily through the tracheostomy. A mask would be difficult to use. The patient, at the time I saw him, was not cyanotic; he had been earlier, and I would be inclined to attribute this to blockage of the trachea with secretions. I think that the sequence of therapeutic efforts were entirely proper. Don't wait to get a tank respirator ready; use something at hand to breathe the patient.

We placed him in a tank respirator to support his respirations for a period of time, inasmuch as we did not know what his status was, whether he was going to fatigue or whether he was fatigued. It is interesting to observe his improvement. He was placed in a respirator at approximately 9:15 A.M. and two hours later he was breathing adequately by himself and was coughing effectively, bringing his secretions up to the tracheostomy tube for suctioning rather than the suction tube having to be passed down to the bronchi. His ability to grip has increased and at approximately 11:00 he was able to squeeze 55 times. At approximately 12:00, just before I came here, he went 71 times.

Dr. Kemble: Would you make a comment for future patients as to the value of your seeing this patient before respiratory difficulty began?

Dr. Hahn: I had seen this patient on several occasions during his hospitalization. An idea as to what his baseline breathing ability was is important. He did not have normal breathing. When he was con-

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sidered fairly comfortable and his medications had been adjusted, his ventilation studies showed that his vital capacity was somewhere between 1500 cc. and 2000 cc. For his body build and age, he should have a vital capacity of approximately 4500 cc. Nevertheless, he was able to breathe adequately and was having no difficulty. I think it is helpful to see such a patient when he does seem stable for an idea of what he is like in his "normal" situation. When he does get into difficulty, we will recognize it. We won't call his usual impairment of breathing ability an indication for giving him respiratory aid; we will know that is what he does on a day by day basis.

Dr. Ahlquist: One of the other obvious actions of these drugs is their effect on cholinergic mediated responses elsewhere in the body. These substances do not act specifically at the skeletal muscle neuromuscular junction; they act at all cholinergic sites, including all autonomic ganglia and all of the endings of the parasympathetic system. At one time it was thought necessary to put patients such as this on atropine continuously to reduce these peripheral autonomic effects. I haven't heard any mention of atropine except as given to the patient this morning because of the excessive secretions during the respiratory difficulty and with the Tensilon® test. Dr. Zerman, would you tell us whether this patient has had any atropine-like drugs during his stay?

Dr. Zerman: No. He has shown no cholinergic actions on the gut or the eye.

Dr. Bailey: The administration of atropine may cover up the effect of the cholinergic agents used and by so doing make you unaware of cholinergic crisis. For this reason, the use of the atropine has been avoided. This morning it was a more extreme situation where we were planning to discontinue this medication anyway and, therefore, we were not hesitant.

Dr. Kemble: Dr. Bailey, remember how red this man's conjunctivae were when he was admitted here? He has a very curious injury to one eye. He has an eyelash imbedded in one cornea. How this got there I don't know. Dr. Fair says that he has seen this two or three times in Europe. This is sticking out of the cornea and anyone can see it. This is part of the corneal irritation. The reason the atropine was used this morning was the fact that this was a cholinergic crisis and atropine might be helpful in managing it. I would like to have Dr. Ahlquist comment on the dosage because high doses of atropine are needed when one is dealing with a cholinergic crisis.

Dr. Ahlquist: If you have a true cholinergic crisis,

you have to presume that acetylcholine is acting excessively every place and you treat the patient much the same as you would treat a farmer who comes in having just ingested a large quantity of Parathion® or some other cholinesterase inhibitor. The dose of atropine that is usually recommended is "enough," starting with two milligrams and continuing until you get a useful effect. Atropine is not really as toxic as one would believe from the size of the usual dose, which is half a milligram. It just means that when atropine is given as a preanesthetic agent, half a milligram is "enough." When you have excessive cholinergic activity, this half milligram is practically nothing and you have to give higher and higher doses.

I think before we close we should mention briefly two things. We should say a word about this quinacrine which was used for Giardia. I think that all the students remember, or should remember, that quinine has a curare-like effect and is not really a desirable thing to give a patient with myasthenia gravis. Quinacrine on the other hand, if it has any effect at all on the cholinergic system, is in itself a cholinesterase inhibitor. It would be a substance that could be used safely in this patient, because all it would do would be to add slightly to the cholinesterase inhibition that you are already producing in the patient.

The last thing we might mention is a new kind of drug. It is not new in some circles. At the Army Chemical Center it is not new because most of the war gases of the future will be cholinesterase inhibitors of the permanent type. These are "permanent" because unless certain chemicals are given, you have to wait for regeneration of cholinesterase. There are a series of substances known chemically as the oximes that have the ability to reactivate cholinesterase. Burroughs and Wellcome, I think, have under clinical trial the pharmaceutical preparation of one of these substances for use in patients with a typical cholinergic crisis. This would be a substance that would be useful in these patients because these are short acting and they activate the cholinesterase. If the patient gets worse with these, you can presume that they are not suffering from a cholinergic crisis. In other words, this will not only be a test for cholinergic crisis, but will actually be treatment as well. You will undoubtedly hear more about these substances.

We might say one word about the drugs used in myasthenia as regards their oral administration. As a class, all of these drugs—neostigmine, pyridostigmine, and edrophonium—are relatively poorly and irregularly absorbed from the gastrointestinal tract. This is one of the theoretical advantages to pyridostigmine (Mestinon®) in that its absorption is a little more reliable, but this does not mean that it

is 100 per cent absorbed. It could be perfectly likely that the patient, up until today, had been absorbing only 50 per cent of what you gave him, and then for some unknown reason, he absorbed the whole dose. The oral treatment of myasthenia gravis has always been a problem. If you could manage it with intravenous infusion, I am sure that the treatment would be much more simple. This, of course, is quite impractical so you have to rely on oral therapy. Another thing that might be blamed is sustained action tablets. It is slowly becoming apparent that many of these are not as good as the manufacturers would have you believe. Most of them depend on the rapidity of the action of the patient's gut. If you get a patient with a fast gut, that patient may get very little of the drug because it may get all the way through into the colon where you have little drug absorption. A patient with a slow gut may absorb it all in a relatively short period of time. Many of these preparations are not really reliable. In many cases, of course, it really doesn't make any difference whether your phenobarbital is absorbed all night long or not.

Nothing really drastic is going to happen if your sustained-action preparation happens to quit working in the middle of the night. But in a case such as this, a serious result can occur.

Student: What are the comparative dosages of these drugs?

Dr. Ahlquist: I think here again the dose is "enough." From a pharmacological standpoint, there are some obvious comparisons as shown by the size of the commonly available tablet. With neostigmine bromide, the tablet is 15 mg.; with Mestinon®, the tablet size is 60 mg., and with Tensilon®, one cc. (10 mg.) is usually considered on dose. With Tensilon® it is a little more difficult, because more of it is used by the anesthesiologist to correct his curare poisoning than is used in the diagnosis of myasthenia gravis. The true difference in potency is not so obvious in patients. It may turn out that in one patient you can get by with a smaller mg. dosage of Mestinon® and you have to take a relatively bigger dose of neostigmine. It is not easy to give an absolute figure.

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THE USE OF A LICORICE PREPARATION FOR THE RELIEF OF GASTROINTESTINAL SYMPTOMS

The most frequent symptoms were gas, abdominal soreness, and epigastric fullness.

Charles W. Hock, M.D., *Augusta*

ALTHOUGH LICORICE HAS been used for many years in Europe as a remedy for digestive disorders, it has been relatively neglected in this country. Recently, intriguing results have been obtained from the use of licorice in Addison's disease¹ and in dermatology² and these have revived interest in the therapeutic action of the drug, including its effect on gastrointestinal disease. Pharmacological tests³ confirm the earlier observations of Nelemans-Stamperious and Nelemans⁴ that licorice reduces the incidence of gastric ulcers in Shay rats; the tests also indicate that this effect is potentiated when licorice is combined with another spasmolytic agent, homatropine methylbromide. These promising results led to the following clinical trial of a medication containing the two substances.

A survey of previous research shows that there were few early reports on the effects of licorice; these are confined to the European literature and describe the healing action of the drug on stomach ulcers in man,^{5,6} its inhibiting effect upon the formation of ulcers in Shay rats,⁴ and its spasmolytic properties.⁷ Investigations of homatropine methylbromide have been more numerous.^{8,9,10,11,12,13} Primarily, their aim has been to compare the toxicity and effectiveness of the drug with that of atropine, since homatropine methylbromide was synthesized during the search for less-toxic substitutes for the belladonna alkaloids. It is now generally accepted that the synthetic compound is 54 times less toxic and only five to 10 times less active than atropine.¹⁴

While both licorice and homatropine methylbromide have been evaluated independently, their joint effect has been reported only in pharma-

cological tests.³ This clinical trial deals with the value of the two drugs combined in a preparation containing 300 mg. ammoniated glycyrrhizin (a purified preparation from licorice) and 0.5 mg. homatropine methylbromide.*

Method

The group studied consisted of 115 individuals seen in the routine practice of gastroenterology. In the group were 65 men and 50 women; with two exceptions they were adults representing all age groups over 20 years. Their distribution in terms of age and sex is shown in Table I. Diagnosis was made after a medical history had been taken, and after each patient had received a complete physical examination, x-ray studies of the gastrointestinal tract including a gastrointestinal series, barium enema, usually a gall bladder series, a sigmoidoscopic examination, stool studies for occult blood, blood counts, Kahn, and urinalysis. In some instances, additional laboratory data, such as liver profile and other chemical studies, were obtained.

TABLE I

AGE AND SEX OF PATIENTS (115)		
Age	Male	Female
0 — 20 yrs.	2	0
21 — 30 yrs.	4	5
31 — 40 yrs.	21	12
41 — 50 yrs.	21	16
51 — 60 yrs.	13	9
61 — 70 yrs.	4	6
71 and over	0	2
Total	65	50

*Supplied by Wallace Laboratories, New Brunswick, New Jersey.

The diagnosis of functional bowel distress was made after reasonable exclusion of organic pathology, and includes a group of patients who complained of gastrointestinal symptoms, which were presumably either psychogenic, or of undetermined etiology. Additionally, it is applied to a group who had determined lesions, but also gastrointestinal symptoms not referable to the lesion. The syndrome was present in 104 (90 per cent) of the patients of which 54 (47 per cent) had functional bowel distress alone; 50 (43 per cent) had it in conjunction with other disorders, of whom 20 (17 per cent) patients had functional bowel distress associated with duodenal ulcer. Only 11 (10 per cent) were without functional bowel distress, but suffered from various diseases of the digestive tract. An analysis of the group in terms of disease is provided in Tables II and III.

TABLE II

DIAGNOSES OF PATIENTS WITH FUNCTIONAL BOWEL DISTRESS AND OTHER DISORDERS (50 PATIENTS)	
Diagnosis Other Than F.B.D.	No. of Cases
None	54
Gastric ulcer	1
Postcholecystectomy	3
Pancreatitis	1
Prepyloric ulcer	2
Postgastrectomy, pyloric ulcer	1
Gastritis	2
Pylorospasm	2
Postgastrectomy	2
Hypothyroidism	1
Duodenal ulcer	20
Duodenal ulcer, diverticulitis	1
Coronary insufficiency	1
Fissure-in-ano	1
Diverticulosis	1
Post-carcinoma, lung	1
Hypoglycemia	1
Epilepsy	1
Pancreatitis, duodenal ulcer	1
Hepatitis	2
Heart disease, hypertension	1
Prepyloric ulcer, gastritis, duodenitis	1
Duodenitis, cardiospasm	1
Duodenal ulcer, fissure-in-ano	1

TABLE III

DIAGNOSES OF PATIENTS WITH GASTROINTESTINAL DISORDERS WITHOUT FUNCTIONAL BOWEL DISTRESS (11 PATIENTS)	
Diagnosis	No. of Cases
Ulcerative colitis	1
Pyloroplasm and diverticulosis	1
Hiatal hernia	1
Diverticulosis, diverticulitis	1
Cholelithiasis	1
Cholecystitis, Cholelithiasis	1
Diverticulitis	1
Diverticulosis	2
Rectal bleeding	1
Pylorospasm	1

In general, the antispasmodic combination was given as an adjunct to other therapy, though there were eight patients who received it as their only medication. The duration of treatment varied from

TABLE IV

DOSAGE, DURATION OF TREATMENT, AND SIDE EFFECTS				
	Length of Treatment	No. of Cases	Side Effects	No. of Side Effects
4 t.i.d.	5 months	1	None	0
	2 months	1	None	0
	1 month	4	(1 — nausea*) (1 numbness*)	0
	2 days	1	(1 — cramping*)	0
3 t.i.d.	6 months	1	None	0
	2 months	1	None	0
	1 month	1	(1 — "gas" worse*)	0
2 t.i.d.	6 months	5	1 — 2 t.i.d. too laxative	1
	5 months	2	None	0
	4 months	3	1 — 2 tablets gave nausea	1
	3 months	2	None	0
	2 months	2	None	0
	1 month	1	None	0
1 q.i.d.	3 months	2	1 — mild diarrhea	1
1 t.i.d.	6 months	3	None	0
	5 months	4	None	0
	4 months	7	None	0
	3 months	28	1 — bad taste gave nausea, 1 — diarrhea	2
	2 months	30	(2 — diarrhea*), 1 — swelling	1
	1 month	14	2 — nausea, 1 — killed appetite, 1 — diarrhea, (1 — itching*)	4
	2 weeks	1	1 — palpitations	1
	1 week	1	(1 — swelling*)	1
Total:		115		12

*Doubtful these were true side effects. Patients were difficult to evaluate and responded poorly to all medication.

one to six months and the dosage varied as shown in Table IV; 76 per cent of the group received three tablets per day—the smallest dose—while larger doses of four, six, nine, and 12 tablets daily were also administered.

A scale of zero to three was used to express relief of symptoms. Subjective appraisals were thus translated into numerical terms: no relief, zero; equivocal to fair relief, one; fair to good relief, two, and good to excellent relief, three. The results were recorded at the end of the trial, but about one-third of the group was evaluated on two separate occasions. Table V lists the symptoms which were studied.

Results

Table V also gives the results of the treatment in the whole group (115 patients) and in three classes of the group:

- Class I—patients with functional bowel distress alone (47 per cent)
- Class II—patients with functional bowel distress together with other disorders (43 per cent)

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Class III—patients with gastrointestinal conditions, but without functional bowel distress (10 per cent).

Of the *total number of symptoms* presented by the whole group, 65 per cent were relieved during treatment. The degree of relief was rated as two or three (fair to excellent); symptoms relieved to a lesser extent were not included in the result. Only 16 per cent of the symptoms were not improved at all. Results were good in all types of patients, though the percentage of symptoms relieved was higher in Class III, those without functional bowel distress. Here, the improvement was 79 per cent as compared with 71 per cent in patients with functional bowel distress (Classes I and II). However, Class III is so small (11 patients) that the difference is not significant.

The most frequent symptoms were gas, abdominal soreness, and epigastric fullness; these were relieved in 72 per cent, 75 per cent, and 76 per cent of the group, respectively. Results were of the same order in all three classes of patients. Other, less frequently occurring, symptoms improved during the study. Patients with abdominal cramps benefited considerably; with 63 per cent being relieved of this symptom. Almost one-half of the group suffered from constipation and in 56 per cent this condition was improved by treatment. Data on other symptoms were insufficient for conclusive results though there were indications of improvement as shown in Table IV.

Eight patients in the study received the antispasmodic combinations as their only medication. Results were comparable to those for the whole group and seven of the eight benefited from therapy.

In the group studied, the antispasmodic combination proved to be extremely safe and free from serious toxic effects at levels of dosage from three to 12 tablets per day. The side effects which did occur are shown in Table IV. Although 19 instances are recorded in Table IV, eight of these occurred in patients known to be influenced by other difficulties; they responded poorly to all medications. Only 11 cases (10 per cent) of side effects were established for the whole group. Four patients complained of the drug's laxative effect, but three of them felt this was unimportant in comparison with the advantages of treatment. There were four cases of nausea, two of which benefited from the medication in other respects. One person felt that nausea resulted from the bad taste of the drug. Single, isolated cases of swelling, depressed appetite, and palpitations were reported; all cleared up when treatment was discontinued.

The incidence of side effects did not appear to be related to dosage. Of the 88 patients receiving three tablets daily, nine per cent experienced some difficulty during treatment; of the 27 patients receiving larger doses, 11 per cent suffered from side effects. Only the complaints established as true side effects were included in these figures.

Comments

This study of a licorice-anticholinergic combina-

TABLE V

RELIEF OF SYMPTOMS IN DIFFERENT CLASSES OF PATIENTS								
	Whole Group (115)		CLASS I		CLASS II		CLASS III	
			Functional Bowel Distress alone (54)		F.B.D. with other Conditions (50)		G-I disorders without F.B.D. (11)	
	No. of patients	Per cent* improved	No. of patients	Per cent improved	No. of patients	Per cent improved	No. of patients	Per cent improved
Gas	111	72	52	75	48	81	8	88
Epigastric fullness	106	76	50	76	45	87	8	88
Abdominal cramps	24	63	9	78	11	73	3	100
Constipation	50	56	23	65	20	80	3	33
Chest pain	19	47	7	—	11	73	1	0
Abdominal pain	17	53	10	50	5	100	3	66
Abdominal soreness	16	75	9	89	5	60	1	100
Diarrhea	15	52	9	44	4	75	0	—
Nausea	3	—	3	—	0	—	0	—
Epigastric burning	12	42	2	—	9	78	0	—
Heartburn	11	45	3	—	6	50	1	100
Sour stomach	1	—	1	—	0	—	0	—
TOTALS	385	65	178	69	164	76	28	79

*Relief of symptoms evaluated as:
 3 — Good to Excellent
 2 — Fair to Good
 1 — Equivocal to Fair
 0 — No relief

Per cent improved includes only those patients with 2 — 3 relief.

tion confirms the results of European investigators. The combination proved valuable in a variety of gastrointestinal complaints, though the cases of functional bowel distress showed the greatest benefit. The majority of patients studied suffered from gas and epigastric fullness; since the medication provided a high degree of relief from these two symptoms, this explains its general usefulness to the whole group.

Twenty patients with duodenal ulcer, all of whom were on ulcer diet, antispasmodics, and sedatives, were given the compound with apparent benefit. Since glycyrrhizin and homatropine separately have been reported beneficial in the treatment of peptic ulcer, it is not surprising that the combination was effective. Since control of spasm is an important consideration in ulcer therapy, the good results observed were possibly due to this antispasmodic property of the compound. From our observations, we would use the licorice compound as adjuvant therapy in the management of peptic ulcer.

Another factor contributing to the usefulness of the medication is its safety. Few toxic effects are expected from the use of glycyrrhizin, while the other constituent, homatropine methylbromide, has the advantage of producing the same therapeutic response as atropine with minimal side effects. This is important with children who are particularly sensitive to atropine, and with older individuals who have a tendency to increased intraocular tension.

Summary

1. An antispasmodic combination of glycyrrhizin and homatropine methylbromide was used in the treatment of 115 patients with gastrointestinal disorders. Treatment was effective in a variety of complaints but was of particular benefit in cases of functional bowel distress.

2. Gas, abdominal soreness, and epigastric fullness, the most frequent symptoms, were relieved in over 70 per cent of the cases.

3. The antispasmodic combination was safe and non-toxic at all dosage levels from three to 12 tablets per day. There were only 11 cases of minor side effects, all of which cleared up when dosage was reduced or the drug discontinued.

1467 Harper Street

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NEW GEORGIA MEMBERS OF A.C.S.

APPROXIMATELY 1,175 SURGEONS were inducted recently in San Francisco as new Fellows of the American College of Surgeons in cap-and-gown ceremonies closing the annual five-day Clinical Congress. The A.C.S., founded in 1913 to establish standards of competency and character for specialists in surgery, has grown in 47 years' time from a founding group of 450 to a total membership of approximately 24,000.

Fellowship, entitling the recipient to the designation, "F.A.C.S.," following his name, is awarded to doctors who fulfill comprehensive requirements for acceptable medical education and advanced training as specialists in one or another of the branches of surgery, and who

give evidence of good moral character and ethical practice.

Those receiving this distinction from the State of Georgia at the 1960 Convocation are as follows: Robert A. Collins, Jr., Americus; H. William Bondurant, William W. Moore, Jr., Louis S. Riccardi, John E. Skandalakis, and William C. Wansker, Atlanta; Alva H. Faulkner, William D. Jennings, Jr., and George W. Smith, Augusta; Benjamin T. Galloway, Brunswick; Calvin L. Edwards, Dalton; Stuart G. Blackshear, John K. Burns, III, and Walter Faust Durden, Gainesville; W. Morris Brown, Jr., R. James Hooper, Claude L. Pennington, and William C. Shirley, Macon; J. Moultrie Lee, Savannah, and Robert C. Behrens, Smyrna.

FOREIGN BODY BRONCHIECTASIS REQUIRING TOTAL PNEUMONECTOMY

Roy H. Crispin, M.D. and William D. Logan, Jr., M.D., *Atlanta*

Emphasis is given to the need for prompt recognition and treatment of foreign body aspiration and of bronchopulmonary disease.

THE RELATIONSHIP OF FOREIGN body aspiration and bronchiectasis is well described. Infrequently, this process involves an entire lung requiring total pneumonectomy.

This is a report of two cases with known foreign body aspiration in childhood resulting in marked bronchiectasis, involving an entire lung.

Most authors do not discuss foreign body bronchiectasis as a separate entity, so the incidence is indefinite. However, Oschner,¹¹ reported 5.2 per cent in a series of 96 cases of bronchiectasis, and Cooley⁴ reported 14 cases of foreign body bronchiectasis in 13 years at the Mayo Clinic. Five of these required total pneumonectomies.

Case Reports

Case No. 1: J. B., a 26-year-old male, was admitted with a chief complaint of left-sided chest pain of four weeks duration. This pain was of intermittent nature and associated with mild dyspnea. He denied hemoptysis, but stated that he had a productive cough every morning. He also gave a history of exertional dyspnea and occasional wheezing since childhood. His past history revealed that he had aspirated a peanut at the age of five followed by a severe respiratory difficulty which subsided spontaneously.

P. E. temperature, 99; blood pressure, 130/80; there was marked tracheal deviation towards the left. Numerous ronchi and wheezes were heard over

the left middle and lower lung fields. He presented no evidence of clubbing.

Chest x-ray on admission (Figure 1) revealed no expansion of the lingula and left lower lobes. There was compensatory emphysema present on the right with mediastinal shift to the left.

Skin tests were negative for tuberculosis, histoplasmosis, coccidioidomycosis, and blastomycosis.

Bronchoscopy revealed a narrowing of the left main stem bronchus with considerable amounts of mucopurulent material in the lumen of same.

Bronchograms (Figures 2 and 3) showed bronchiectatic changes in all of the major divisions of the left strictured bronchus and contracture of the entire left lung. The above mentioned compensatory emphysema on the right was also evident.

A total left pneumonectomy was done on October 12, 1959. Pathologically, the specimen presented extensive saccular bronchiectasis.

The patient's course in the hospital was uneventful, and he was dismissed on October 21, 1959.

Case No. 2: S.G.C., an 18-year-old female, was admitted with a chief complaint of asthma and shortness of breath. Her symptoms began following aspiration of a foreign body at the age of six. The nature of the foreign body was not known, but she received no definitive treatment at that time. She gave a history of occasional hemoptysis. The patient had received numerous regimens of treatment for her asthma and cough, but no pulmonary studies were done.

P. E. temperature, 98.6; blood pressure, 118/70; diminished breath sounds were noted over the left hemithorax with rales in the left lower lobe. There was an increased percussion note over her right upper lobe. No clubbing was noted. On fluoroscopy the right upper lobe was emphysematous with mediastinal herniation into the left upper chest.

Skin tests were negative for tuberculosis, histoplasmosis, coccidioidomycosis, and blastomycosis.

From the Department of Thoracic and Cardiovascular Surgery, Crawford W. Long Memorial Hospital of Emory University, Atlanta, Georgia.

Dr. Crispin is a Resident in Surgery.

Presented at the Atlanta Surgical Residents' Society, Spring 1960, Atlanta, Georgia.

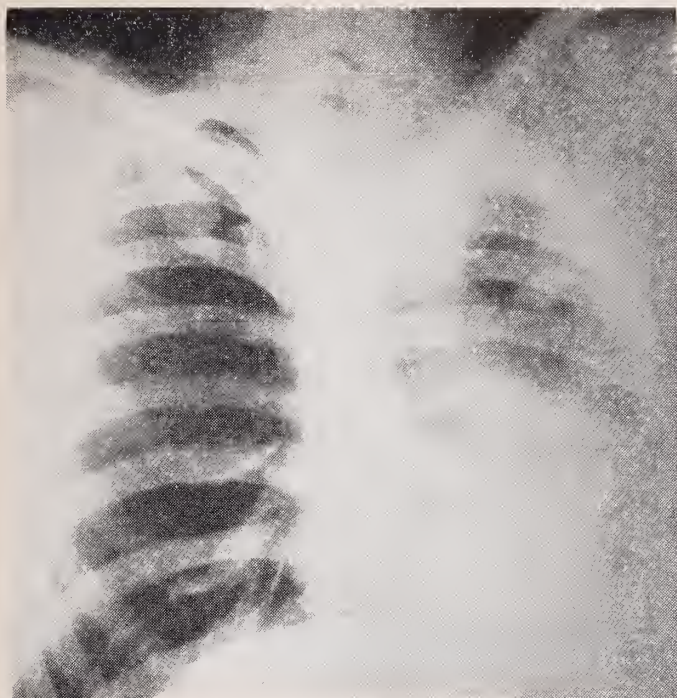


Figure 1.

Bronchoscopy revealed evidence of tracheobronchitis, and bronchial washings taken were reported negative for bacteriology and pathology. Chest x-ray at this time revealed (Figure 4) the above mentioned herniation of the right lung through the mediastinum into the left chest.

Bronchoscopy revealed evidence of tracheobronchiectatic changes involving all of the branches of the left main stem bronchus. All the divisions of the left upper and lower lobe bronchi were contracted and showed marked cystic bronchiectatic changes. No bronchiectasis were seen on the right. X-rays of her sinuses were reported as normal.

A total left pneumonectomy was done on Novem-

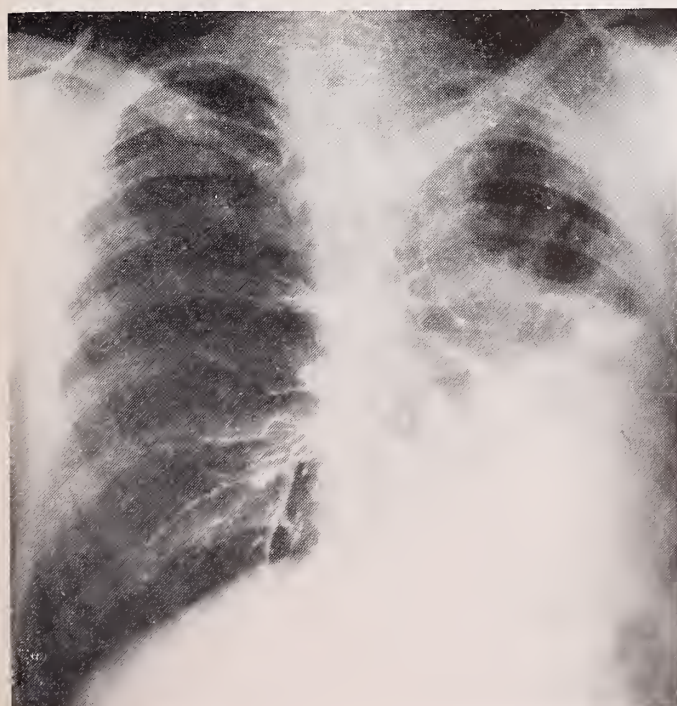


Figure 2.

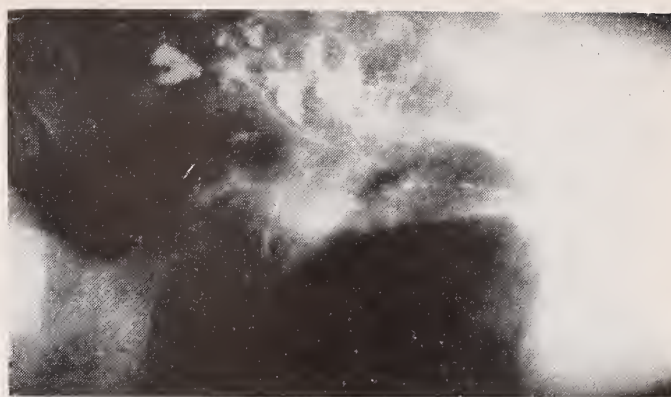


Figure 3.

ber 17, 1959, without difficulty. She did well post-operatively and was dismissed on November 27, 1959.

The pathology report was left lung showing extensive bronchiectasis and chronic reactive lymphadenitis.

Discussion

Bronchiectasis is characterized by dilated, damaged bronchi associated with changes in the surrounding parenchyma. It is generally accepted that bronchiectasis is caused by a combination of infection and obstruction of the bronchi. Aspirated foreign bodies offer ideal conditions for the development of bronchiectasis. The manner of mechanical obstruction from foreign bodies is described by Chevalier Jackson as follows:^{6,7}

"By-pass valve action occurs when the foreign body is of a size and shape or lodged at a point where air can pass by it on both inspiration and expiration. Since there is no obstruction to the flow of air, there will be no change on x-ray, and very little will be



Figure 4.



Figure 5.

found on physical examination other than possibly a wheeze. As the air space around the foreign body decreases due to edema of the mucosa or to the further progress of the foreign body into the smaller bronchi, the check-valve phenomenon occurs. This is based on the change in the lumen of the bronchi with enlargement during inspiration and decrease during expiration. As a result, when the air space reaches a point where air can enter on inspiration but is trapped on expiration, the picture of obstructive emphysema occurs. When the foreign body lodges at a point where air can leave but not enter, a ball-valve action results in atelectasis. This phenomenon is occasionally intermittent, which complicates diagnosis.

"The final stage is the stop-valve phenomenon, where neither inspiration nor expiration result in air exchange, and the portion of lung involved becomes completely atelectatic."

It has been shown by Croxatto and Lanari⁵ that bronchial obstruction could explain all forms of bronchiectasis. These authors took dogs and ligated certain bronchi. In every case the surrounding parenchyma became atelectatic, but no gross dilatation was seen until the sixth day, and this was due to the pressure that the accumulated mucus was exercising on the wall of the bronchi. The filling of the dilated bronchi with mucus continued for two months after the block, and until this time, there was no evidence of fibrosis, but if the obstruction was not relieved at this time, fibrinous organization of the mucus began in the bronchioles.

Obviously, this has not always been able to be proved, but if one considers edema, narrowing of the bronchial lumen, severe pneumonitis plus thickened secretions, and an inadequate cough reflex, this could well explain bronchial obstruction such as one would see with a totally occluding foreign body. Thus, one could explain all bronchiectasis on the basis of bronchial obstruction.

Another important detail which was demonstrated by these authors was that if they relieved the bronchial obstruction before the two months mentioned above, the dilatation is reversible and the bronchi return to their normal size. This has been described by other authors and named "Pseudobronchiectasis" by Blades.² All foreign bodies should be removed as soon as possible; this point cannot be stressed enough.

Bronchoscopy offers the most satisfactory method of removing foreign bodies, and should be used when at all possible. This procedure may occasionally have to be repeated to find foreign bodies which are surrounded with mucus or mucopurulent material and edema, but this only emphasizes the importance of the procedure. In some cases there is a symptomless period following aspiration with negative physical findings which may be misleading. A positive history of aspiration, regardless of symptoms or physical findings, warrants bronchoscopy. X-ray findings may not offer a positive diagnosis of a foreign body unless it is opaque.

In the two cases reported here, there was a definite history of foreign body aspiration during early childhood which was never properly treated. Following the episodes of aspiration, both patients developed rather significant signs of bronchopulmonary disease with cough, wheezing, and some dyspnea, but again no definitive pulmonary work-up was done to evaluate the etiology of these symptoms. All too frequently the diagnosis of asthma is made and some symptomatic treatment given without proper consideration of etiology. Notwithstanding the lack of proper treatment of the aspirated foreign body and development of bronchiectasis, the correct evaluation of the bronchopulmonary disease could have resulted in earlier treatment and prevented the years of symptom complexes that these patients suffered. Both of these patients have had excellent results from their surgery, as has been reported in other cases of this nature.

Summary

1. Two cases of bronchiectasis following foreign body aspiration requiring total pneumonectomies are presented.
2. Prompt recognition and treatment of foreign

body aspiration is imperative to prevent permanent lung damage.

3. Prompt recognition and proper evaluation concerning the etiology of respiratory symptoms in the young age group is stressed.

4. Bronchoscopy is the most valuable adjunct in the treatment of aspirated foreign bodies.

5. There may be a symptomless period with insignificant x-ray findings associated with aspirated foreign bodies, and this should not be misleading. A positive history of aspiration alone warrants bronchoscopy.

Crawford W. Long Memorial Hospital

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1960-61 CALENDAR OF MEETINGS

State

Jan. 16-20—Basic Science Lecture sponsored by The Sisters of Mercy and the Medical Staff of St. Joseph's Infirmary, St. Joseph's Infirmary, Atlanta.

Jan. 24-26—"Problems of the Newborn Infant," Medical College of Georgia, Augusta.

Feb. 13-17—Basic Science Lecture sponsored by The Sisters of Mercy and the Medical Staff of St. Joseph's Infirmary, St. Joseph's Infirmary, Atlanta.

Feb. 19-22—Atlanta Graduate Assembly, Biltmore Hotel, Atlanta.

Feb. 28-Mar. 2—"Management of Your Patient with Vascular Disease," Medical College of Georgia, Augusta.

Mar. 20-24—Basic Science Lecture sponsored by The Sisters of Mercy and the Medical Staff of St. Joseph's Infirmary, St. Joseph's Infirmary, Atlanta.

May 7-10—Annual Session, Medical Association of Georgia, Atlanta Biltmore Hotel, Atlanta.

Regional

Jan. 16-18—Sectional Meeting, American College of Surgeons, Hotel Dinkler-Tutwiler, Birmingham, Alabama.

Mar. 6-9—Southeastern Surgical Congress, Deauville Hotel, Miami Beach, Florida.

Apr. 9-12—Tennessee State Medical Association, Read House Hotel, Chattanooga, Tennessee.

Apr. 22-25—Texas Medical Association, Galvez and Buccaneer Hotels, Galveston, Texas.

National

Dec. 28-Jan. 7—Third Surgical Conference, Bahamas Conferences, Nassau, Bahamas.

Jan. 8-13—American Academy of Orthopaedic Surgeons, Hotel Americana, Bal Harbour, Miami Beach, Florida.

Jan. 8-14—Conference on Hypertension, Bahamas Conferences, Nassau, Bahamas.

Jan. 9-13—Postgraduate Course in Recent Advances in Drug Therapy, American College of Physicians, University of Washington School of Medicine, Seattle, Washington.

Jan. 9-14—Postgraduate Course in General Practice Review, University of Colorado Medical Center, Denver, Colorado.

Jan. 12-14—Ninth Annual Cancer Seminar, Arizona Division of ACS, Tideland Motor Inn, Tucson, Arizona.

Jan. 16-20—Postgraduate Course in Mechanisms of Disease, American College of Physicians, Columbia University College of Physicians and Surgeons, Presbyterian Hospital, New York, New York.

Jan. 22-28—Third Serendipity Conference, Bahamas Conferences, Nassau, Bahamas.

Jan. 23-25—The 25th Annual Session of the International Assembly of Southwest Texas, Granada Hotel, San Antonio, Texas.

Jan. 26-28—Rocky Mountain Traumatic Surgical Society, The Aspen Meadows, Aspen, Colorado.

Feb. 4-7—Congress on Medical Education and Licensure, Palmer House, Chicago, Illinois.

Feb. 6-8—American Academy of Allergy, Statler-Hilton Hotel, Washington, D. C.

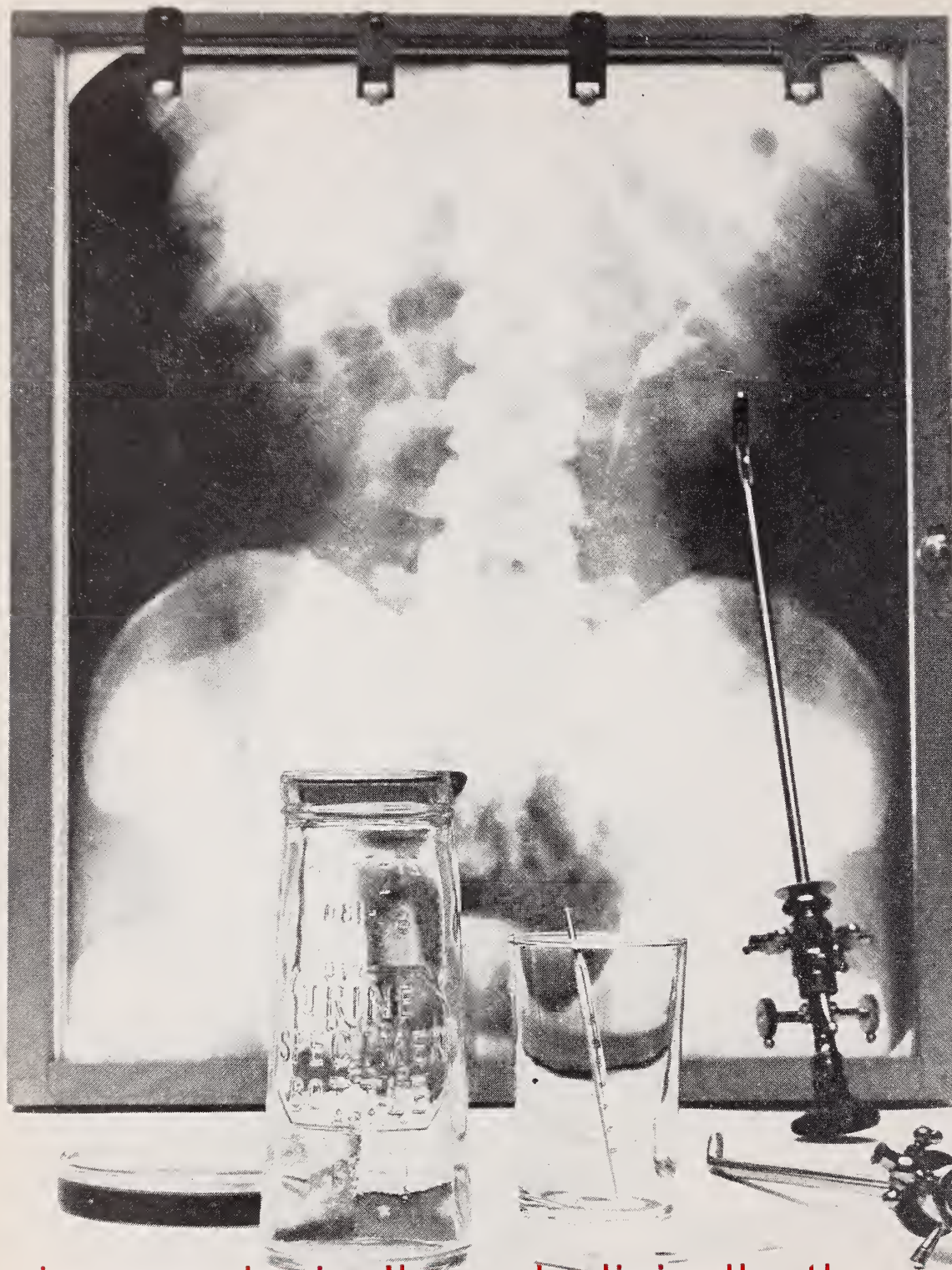
Feb. 8-11—American College of Radiology, Drake Hotel, Chicago, Illinois.

Feb. 9-15—Second Allergy Conference, Bahamas Conferences, Nassau, Bahamas.

Feb. 20-24—Postgraduate Course in Selected Topics in Internal Medicine, American College of Physicians, University of Oklahoma School of Medicine and University Hospitals, Oklahoma City, Oklahoma.

Mar. 20-24—Postgraduate Course in Medical Technology, University of Colorado Medical Center, Denver, Colorado.

Mar. 20-24—American Surgical Association, Boca Raton Hotel, Boca Raton, Florida.



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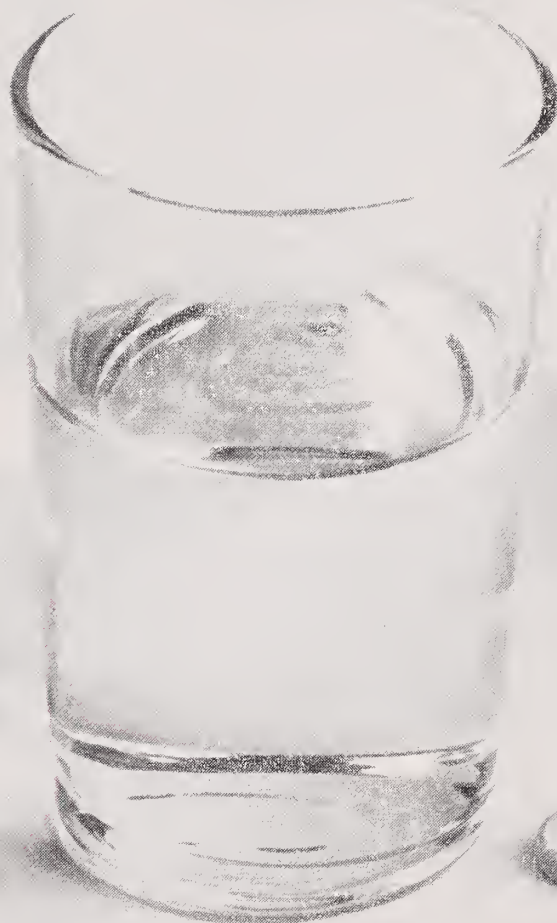
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editorials

Medical Technology

AS MEDICAL KNOWLEDGE increased and laboratory procedures were developed, it became necessary for physicians to train assistants to help perform tests. Realizing the need for establishing uniform practices in training laboratory assistants, the American Society of Clinical Pathologists established the Registry of Medical Technologists in 1928. Through its efforts, the Registry has come to be recognized as the only authoritative qualifying body for this field.

It has elevated the status of the medical laboratory worker to a high professional level by gradually raising the educational requirements and broadening and improving the technical training.

The Board of Registry of Medical Technologists is a standing committee of the American Society of Clinical Pathologists and consists of five members of the American Society of Clinical Pathologists and four members of the American Society of Medical Technologists.

The Registry is a non-profit organization, and the members of the Board of Registry and the official examiners throughout the country receive no compensation.

The general certification is that of Medical Technologist, though several other classifications have been established. At the present time, pre-technical training requirements are: (1) graduation from an accredited high school or equivalent, and (2) two years (60 semester hours) of college work in any college or university accredited by a recognized standardizing association. There are specific requirements of 18 quarter hours of biology and 13-19 quarter hours of chemistry.

Effective January 1962, the pre-technical educational requirements will be three years (90 semester

or 135 quarter hours) of college training. This should lead to a baccalaureate degree in Medical Technology.

There are specialist certifications requiring a master's degree or doctorate in the specialty. In addition, certification is available in histologic technic, chemistry, microbiology, blood banking, and exfoliative cytology.

The Code of Ethics is consistent with the Code of Ethics of the American Medical Association and listed as "Standards of Conduct for Medical Technologists." They are as follows:

I. A medical technologist will work at all times under the direction or supervision of a pathologist or other duly qualified and licensed doctor of medicine, such qualifications being determined on the basis of accepted medical ethics.

It is ethical to work as a medical technologist in a research laboratory, a public health laboratory, or accredited teaching institution when such work is done under the direction or supervision of a duly qualified doctor of medicine.

II. A medical technologist will not act as owner, co-owner, advisor, or employee, or by means of any subterfuge, participate in an arrangement whereby an individual not regularly licensed to practice medicine is enabled to operate a laboratory of clinical pathology.

III. A medical technologist will make no interpretations of results of laboratory procedures other than technical aspects of tests employed.

IV. A medical technologist will not advise physicians or others relative to the diagnosis or treatment of disease.

V. A medical technologist will not train student medical technologists on a regularly scheduled or formal basis in any branch of medical technology unless this training is under the supervision of a clinical pathologist and/or in a manner

prescribed by the Council on Medical Education and Hospitals of the American Medical Association.

VI. It is ethical to work as medical technologist on a commission basis under contract with a public health, research, or clinical laboratory when such work is done as provided in Section I above, and when all contractual agreements are approved and signed by the director of the organization contracting for such services.

VII. These Standards of Conduct shall be consistent with the Code of Ethics of the American Society of Clinical Pathologists and that of the American Medical Association.

The training curriculum is not less than 12 months and includes the following subjects: biochemistry, hematology, bacteriology, parasitology, histologic technic, serology, urinalysis, blood banking, basal metabolism, clinical microscopy, and radioisotopes.

It is evident that the number of individuals entering medical technology training is inadequate and that with an added year as prerequisite this number may be decreased.

The demand for medical technologists is increasing and will continue to do so with the constantly rising population and with new hospitals and research centers being constructed.

To have properly trained and motivated medical technologists is of greatest importance in view of the performance of procedures by medical technologists which may be lifesaving or death-dealing—such as cross-matching blood. The inherent value of any apparatus or procedure is less important than the skill with which it is used. Improperly performed procedures, casualness, lack of proper motivation, and inadequate training can lead to inestimable harm to the patient and mislead the physician in his care for the patient.

It is imperative that these things be realized and that we take appropriate steps to direct properly motivated young people into the field of medical technology and to give them proper training in this field.

*John T. Godwin, M.D., President
Georgia Association of Pathologists*

Enuresis

APPROXIMATELY 10 PER CENT OF children age four and one-half years have enuresis and less than 10 per cent of this group have an organic lesion as the basis of continued bed wetting.

During the first year of life, the bladder acts automatically without benefit of control from higher centers of the central nervous system. The development of urinary control begins during the second year of life as the child becomes aware of a full bladder and begins to indicate this to his parents. The next stage of development follows shortly as the child learns to "hold" his urine for brief intervals. The ability of higher centers of the central nervous system to inhibit the detrusor reflex is now coming into play. The bladder capacity now begins to increase and daytime control usually is well established during the third year. The ability to initiate urination and to stop urination *at will* is usually gained during the third or fourth year. *If sufficient daytime bladder capacity has now been established*, the child can retain the nocturnal renal outflow without wetting the bed. A bladder capacity of 10 to 12

ozs. is necessary for comfortable retention of the nocturnal urine of the average three to four-year-old child.

The bladder capacity of the primary enuretic child is much less than that of a normal child and is thought to be due to poorly directed use of his voluntary control mechanisms. Encouraging the child to void frequently during the day, restriction of fluid intake, devices to wake the child, getting the child up to void during the middle of the night, and other such tricks to save the laundry, simply perpetuate the basic difficulty—a small bladder capacity.

Treatment can now be logically directed toward the basic problem of increasing the bladder capacity. If the parents and child are cooperative, this can usually be accomplished by starting a daytime "voiding chart" noting the amount and time. When the pattern is determined, the child is actively encouraged to increase the length of time between micturition and the amount which he passes each time until a capacity of 10-12 ozs. is obtained. If progress appears to be slow, anticholinergic drugs such as

EDITORIALS / Continued

propantheline (Pro-Banthine®) will relax the detrusor and increase bladder capacity. During this period of training, the wet bed is best ignored and the child should not be encouraged to urinate "before you wet your panties."

Many children will escape urological instrumentation and retrograde ejaculation during adult years resulting from transurethral resection of the vesical

neck if these simple measures outlined above are initiated as the first step in the management of the enuretic who has no history of recurrent urinary infection or obvious genital anomalies.

The following article by Muellner is more than worthy of the time necessary to locate and study it: Muellner, S. R.: Development of Urinary Control in Children, J.A.M.A. 172:1256-1261, 1960.

Samuel S. Ambrose, M.D.

Am I Beholden?

RECENTLY IT HAS become apparent, that on the part of some physicians, certain definite, predetermined patterns (factually substantiated) for increasing patient "load" have been established. Previously, the presentation of personal technics, problem cases, methods, etc., either in the literature—or from the podium—has often given an onlooker the impression of so-called ethical advertising. More mature minds have accepted such effort as evidence of honest intent—medical education, a form of increased social intercourse with fellow physicians, or even more simply such interest and enthusiasm in a problem that the doctor just had to express himself. One is inclined to believe that such motivation is to be encouraged. As in prior years, most physicians today depend on ability, an average bedside manner, and a moralistic attitude and fee scale to do their "advertising" for them. In turn, over a period of years, they have accumulated a satisfactory practice, and clothed and fed their families well. Simultaneously, they have been invited, on the basis of these achievements, to undertake increasing responsibility, be called more frequently in consultation, and be sought out and invited by various agencies to care for subsidized patients.

Lately, we hear that ours, the second oldest profession, too frequently has usurped a method formerly coveted only by the oldest—outright soliciting.

*Webster's New Collegiate Dictionary, G. & C. Merriam & Co. Publ., 1953.

*Solicit**—to entreat, approach with a request (as in begging), to try to obtain by asking for, etc. Technics, basically the same, vary in subtleties. Motivations are simple and consist of egocentricity, measurable success, or increased remuneration. The stimulus for such activity can often be attributed to increased financial demands and/or strenuous competition in a given area. More aggressive approaches vary in form or degree. They consist of door-to-door visits by physicians to colleagues blatantly asking for direct referrals, or similar requests by phone or in writing to agencies able to send fee-guaranteed patients. Also, there are pleas to empaneled physicians for assistance. Physicians have subjected themselves to political patronage practices to gain fee—for service contracts from city and state organizations. Ingratiating oneself with the emergency clinic nurse to assure direct referral of unconnected potential private patients is another method.

More subtle, perhaps, is the free lunch or the constantly rotating invitational lists for doctor and wife at the club.

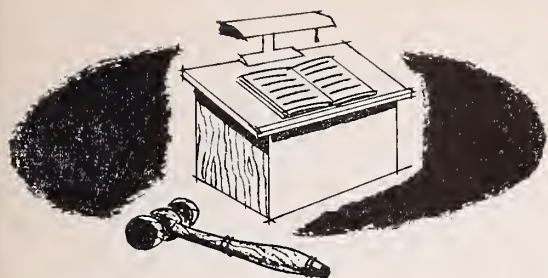
Fortunately, these methods are recognized as exception rather than rule. Continued use, however, could set a poor example for our newer members. Such activities remain as a poor reflection on our profession. Solution may only be arrived at on an individual basis—recognition arousing suspicion—since this is such a "fringe area" as far as ethics is concerned.

Medical Association of Georgia — 107th Annual Session

Atlanta Biltmore Hotel

May 7-10, 1961

Atlanta, Georgia



president's letter

THE STAKES ARE HIGH — AND THEY'RE YOURS!

ABOUT THIS TIME, as we get ready for the coming year, each component of the state medical association elects and installs its officers for the ensuing year. This is a duty which should not be taken lightly, as your elected officials are the ones who will guide and at this critical period, we might say, determine the destiny of the practice of medicine as we now have it in this country.

Your Medical Association of Georgia, realizing this, has attempted to assist in preparing the officers for their responsibilities and duties. The annual meeting for county society officers and, of course, other interested members, is designed to help and make it easier, as well as attempting to give each individual a firmer understanding of some of the problems which face the medical profession. It is of vital importance to each individual physician and the future physicians of this state that all participate and cooperate.

The philosophy of the people of the United States appears to be changing, and probably the philosophy of the individual physician is also changing. It is your duty, as it is of all physicians, to prepare yourselves to cope with the situations which may arise and always consider what is best for the patient and for the highest type of medical practice, irrespective of the pressure which outside groups may place upon you.

It is the feeling of the majority of physicians that the individual voluntary type of medical practice, whereby the individual has the right to select his own physician and the physician to select his own patient, is the best way. It is this type philosophy, the system of free enterprise, which has made America the great nation it is and American medicine what it is today.

Today the philosophy and the nature of the American people seems to have changed. The individual seems to be becoming a "leaner," with the desire to "let George do it" and "let my neighbor take care of me and mine." This country has been

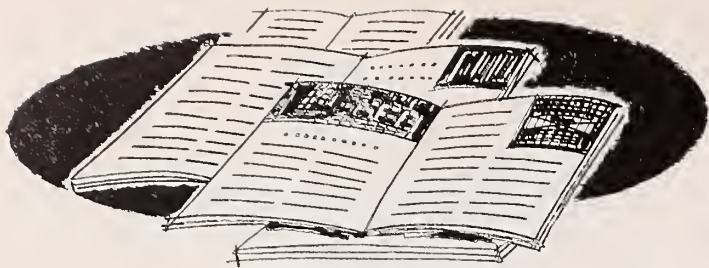


MILFORD B. HATCHER, M.D.

built by rugged individuals working harmoniously for the betterment of a society that would benefit all, but the individual upon his own merit and hard work.

One of the ways we can help maintain our system of medical practice is to discourage our patients from abusing their hospital insurance and using it excessively. As the costs of medical care have risen, it has been found that hospital care and other auxiliary care has risen much faster than have actual medical or physicians' fees. Excessive use of hospital insurance inevitably results in higher and eventually prohibitive costs of this insurance, and this voluntary health insurance is one of our main weapons in our fight against socialization of medical practice. Therefore, it is to our definite advantage, particularly in the long run, to try to discourage this abuse which we are so often now encountering. The stakes are high—and they're yours!!

President, Medical Association of Georgia



current clinical concepts

Roentgen Diagnosis of the Cardioesophageal Junctionure

FOR MANY YEARS IT has been the impression that the diagnosis of hiatal hernia was made more frequently than expected, as compared to the incidence in the literature variously reported from one per cent to 12 per cent, with an average of about three per cent. In the Department of Radiology, University of Pennsylvania, a pilot study of 100 consecutive adults, referred for study of the upper gastrointestinal tract, was carried out. Conventional x-ray equipment was used and a simplified procedure was performed. Under the age of 40 years, an incidence of hernias was found to be 38 per cent in males and 30 per cent in females. Over the age of 40, the incidence was 65 per cent in males and 50 per cent in females. Therefore, the overall incidence in the entire series of 100 adults was 50 per cent.

Finklestein, Arthur K., M.D.: Roentgen Diagnosis of the Cardioesophageal Junctionure, presented at the American College of Gastroenterology, Oct. 24-26, 1960, Philadelphia, Pa.

Diagnosis of an Enterocoele

DR. TYRONE EMPHASIZED the necessity for suspecting the diagnosis of an enterocoele. To make this diagnosis one must do a combined rectal and vaginal examination, and, if there is evidence of an enterocoele, the loop of the small bowel and/or large bowel will be felt during this combined typed of examination. The greatest number of patients having this enterocoele are in the fifth decade. He emphasized the symptoms and signs of this lesion as being (1) protrusion of the vagina, (2) difficulty with defecation, (3) difficulty with squatting, (4) pelvic pain, (5) dyspareunia, and (6) backache.

In a humorous vein he concluded his discussion of this subject with the following observation as made by his former professor: "If a vaginal plastic and/or hysterectomy is performed in patients who

have an enterocoele and the latter is not recognized, one might as well have sewn up the patient's drawers, insofar as relieving her of her symptoms."

Tyrone, Curtis, M. D., Tulane University, New Orleans, La., presented at the 15th Annual Session, American College of Surgeons, Georgia Chapter, Sept. 29-Oct. 1, 1960, The Cloister, Sea Island, Ga.

Primary Ureteral Carcinoma

PRIMARY URETERAL CARCINOMA is not a rare entity as formerly thought, and, while uncommon, occurs with sufficient frequency to demand cystoscopy and retrograde pyelourography for all cases of gross hematuria.

Editorial Staff: Primary Ureteral Carcinoma, J.A.M.A. 174:1322, Nov. 5, 1960.

Measles-Virus Vaccine

IMMUNITY TO MEASLES is desirable because the natural disease causes widespread illness often with complications. An attenuated measles-virus vaccine which protects against measles and has few undesirable side effects is now available for clinical trial.

Katz, Samuel L., et al.: Studies On An Attenuated Measles-Virus Vaccine, N. Eng. J. Med. 263:180-184, 1960.

The Changing Incidence and Treatment of Thyroid Disease

SURGICAL ADMISSIONS FOR disease of the thyroid gland have diminished from 14.8 per cent of all surgical admissions to 5.2 per cent, during the period 1936-1959. Patients with toxic diffuse goiter who, in 1936, accounted for 44.6 per cent of all surgery of the thyroid now account for only 19 per cent of such surgery, whereas, patients with toxic nodular goiter who, in 1936, accounted for 34.8 per cent of all surgery of the thyroid now are responsible for only 6.9 per cent of such surgery.

Patients with chronic thyroiditis have increased

sevenfold since 1936 and now represent 5.6 per cent of the surgery of the thyroid gland.

Carcinoma is the reason for 6.9 per cent of our thyroid operations at the present time, representing more than three times the incidence of 2.1 per cent reported in 1936.

Fowler, Edson F., M.D.: The Changing Incidence and Treatment of Thyroid Disease, *Arch. Surg.* 81, Nov., 1960.

Pheochromocytoma

EIGHT HUNDRED PEOPLE die annually in the United States from pheochromocytoma. It is more common than originally thought and as a curable disease, it represents a great tragedy when undiagnosed. With paroxysmal hypertension, a diagnosis of pheochromocytoma is confirmed, if increase in blood pressure is precipitated by histamine. This test may be dangerous and should not be used if the blood pressure is considerably elevated.

Perhaps the most important test is the quantitative determination of the urinary catecholamines, epinephrine, and levarterenol. When these substance are greatly increased, the diagnosis is almost certain. When this condition is present and unrecognized, operation for unrelated conditions frequently proves disastrous.

Diefendorf, R.O., M.D.; O'Donnell, A., M.D., and Creelman, E. W., M.D.: Pheochromocytoma, *Arch. Surg.* 81, Nov., 1960.

The Incidence of Carcinoma at the Esophagogastric Junction in Short Esophagus

A REVIEW OF THE authors series and experiences indicates that an adenocarcinoma of the stomach occurs much more frequently in patients with a congenitally short esophagus. The authors believe that a short esophagus is best treated by resection in the lower esophagus and the upper stomach, together with some type of antrectomy or suitable drainage procedure. In a series of 87 cases with a congenitally short esophagus, they found 6.9 per cent to have carcinoma.

Stemmer, Edward A., M.D. and Adams, William E., M.D.: The Incidence of Carcinoma at the Esophagogastric Junction in Short Esophagus, *Arch. Surg.* 81, Nov., 1960.

Pulmonary Hemosiderosis

CHARACTERISTICALLY, IDIOPATHIC pulmonary hemosiderosis in the adult presents with cough, hemoptysis, fever, dyspnea, and bradycardia, resembling in many respects an acute respiratory infection. Roentgenograms of the chest most commonly reveal diffuse mottled opacities with reticular designs resembling those seen in a viral pneumonia. These are usually basilar, but may radiate out from a hilum, suggestive of early pulmonary edema. As time progresses,

pallor becomes more prominent, and the patient may become frankly icteric.

Laboratory studies disclosed a hypochromic microcytic anemia, often severe, with anisocytosis and poikilocytosis on smear, and a reticulocytosis. A leukocytosis may be present. Bilirubinemia, predominantly in the indirect fraction, and the excretion of excess amounts of urobilogen are often present, suggesting a hemolytic process, but serum iron and iron-binding capacity are characteristic of a severe iron deficiency anemia. Its occurrence may be explained on the basis of repeated intra-alveolar hemorrhage. However, the etiology of the disease remains controversial, various theories having been proposed.

Denson, H.B.: Idiopathic Pulmonary Hemosiderosis: An Adult Case with Acute Onset, Short Course, and Sudden, Fatal Outcome, *Ann. Int. Med.* 53: 579-585, 1960.

Bone Disease in Lupus Erythematosus

ELEVEN PATIENTS IN A series of 400 cases of systemic lupus erythematosus developed avascular bone necrosis which lead to severe incapacitation in eight. There was bilateral femoral-head involvement in eight, and unilateral involvement in one.

Dubois, E. L. and Couzen, L.: Avascular Bone Necrosis with Systemic Lupus Erythematosus, *J.A.M.A.* 174: 966-971, 1960.

Spontaneous Chylothorax in Neonates

CHYLOTHORAX IS A RARE cause of acute respiratory distress in the newborn infant. The diagnosis is made from clinical manifestations of respiratory difficulty, roentgenographic evidence of pleural effusion, and aspiration of chyle. Birth trauma or congenital abnormalities of the thoracic duct system are the most likely etiologies.

Conservative measures in most patients with repeated thoracenteses to remove the chyle and permit expansion of the lung is the treatment of choice.

Boles, E. T., Jr. and Izant, R. J., Jr.: Spontaneous Chylothorax in Neonatal Period, *Am. J. Surg.* 99:833-986, 1960.

Automobile Crash Injuries

DR. NORTH AGAIN EMPHASIZED the very important fact, as borne out by the studies of the Cornell Medical School, as well as by the Ford Foundation, that seat belts in automobiles made them (the latter) two times safer. He again emphasized the fact that the ejection injuries accounted for a goodly number of the fatal injuries in automobile accidents.

North, Paul, M. D., Dallas, Tex.: Automobile Crash Injuries, presented at the 15th Annual Session, American College of Surgeons, Georgia Chapter, Sept. 29 - Oct. 1, 1960, The Cloister, Sea Island, Ga.

The Sulfonamides

IN SOME SITUATIONS the sulfonamides serve as satis-

CLINICAL CONCEPTS / Continued

factory substitutes for other antimicrobial compounds and may, indeed, be preferable. This is one of three comprehensive articles that should be the reference material for every practicing physician.

Weinstein, Louis; Madoff, Morton A., and Samet, Charles M.: The Sulfonamides, *N. Eng. J. Med.* 263:18, Nov. 3, 1960.

Small Intestinal Obstruction in the Absence of Positive Roentgen Findings

ROENTGEN EXAMINATION OF the abdomen is a useful aid in the diagnosis and management of intestinal obstruction. Under certain circumstances, however, normal roentgen findings may exist in the presence of complete small intestinal obstruction. Most usually this occurs when intestinal obstruction is: (1) early, (2) exists and the patient has not swallowed enough air, and (3) "closed loop."

Zaslow, Jerry, M.D.: Small Intestinal Obstruction in the Absence of Positive Roentgen Findings, presented at the American College of Gastroenterology, Oct. 24-26, 1960, Philadelphia, Pa.

Physicians in a Changing World

IT BECOMES increasingly necessary that every American physician to arm himself with the knowledge and awareness of his adversaries' position. Dr. Judd succinctly outlines what is before us, what will happen if we capitulate to the totalitarian dreamers, and, most importantly, what the American physician can do in this struggle for the control of the mind, the soul, and, indeed, the whole man.

Judd, Walter H.: Physicians in a Changing World, *N. Eng. J. Med.* 263:18, Nov. 3, 1960.

Tumors of the Neck

DR. BROWN EMPHASIZED that a midline tumor in the anterior aspect of the neck might possibly represent, in some circumstances, an entire thyroid gland. Certainly, it would be wise, in such an instance, to search for the normal thyroid gland, if it were in this location to determine its presence prior to removing the entire lesion without thought of this being total thyroidectomy.

Brown, Robert D., M.D., Bethesda, Md.: Tumors of the Neck, presented at the 15th Annual Session, American College of Surgeons, Georgia Chapter, Sept. 29-Oct. 1, 1960, The Cloister, Sea Island, Ga.

NEW DOCUMENTARY HISTORY OF MEDICINE AVAILABLE FOR MEDICAL AND LAY SHOWINGS

A NON-COMMERCIAL, capsule history of medicine—from ancient time to the present—has been produced by White Laboratories and is available for medical and lay group showings. Title of the film is "69.3."

This unusual title is derived from the theme of the film, which reveals how medical progress over the years has helped raise our average life expectancy at birth from about 20 years in ancient time to the present 69.3 today.

The film is narrated by Alistair Cooke, who gained fame on the TV series, "Omnibus," and was written by Irve Tunick, winner of the Robert E. Sherwood writing award. Dr. Robert L. Swain was technical advisor.

The documentary is a black-and-white 16 mm. film, and runs 13½ minutes. Requests for free bookings should be sent to: Institute of Visual Communications, Inc., 40 East 49th Street, New York 17, N. Y.

DENTIST ELECTED CHAIRMAN STATE BOARD OF HEALTH

FOR THE FIRST time in its history, the State Board of Health has selected a dentist as Chairman.

Dr. J. G. Williams, Atlanta dentist and member of the Board since 1931, succeeds Dr. Fred H. Simonton, practicing physician from Chickamauga.

The new vice-chairman is Dr. A. M. Phillips, Macon, who succeeds Dr. J. M. Byne, Jr., of Waynesboro.

The new chairman has served on the Board of Health longer than any other member. In addition, Dr. Williams began a state-wide dental health program for the Georgia Department of Public Health in 1932. He directed this program without salary until a full-time dental director was employed by the Department in 1953.

Commenting on his election, Dr. Williams said, "this shows that dentistry is recognized by the medical profession as an important part of the total public

health program." Noting the responsibilities of the Board Chairman, Dr. Williams said, "this is the biggest job of my life."

Dr. Williams is a charter member and past-president of the American Association of Public Health Dentists, a member of the American Public Health Association, and a former president of the Georgia Public Health Association.

He is a member of the American Dental Association, Georgia Dental Association, and several other professional and honorary organizations.

The State Board of Health has 14 members appointed by the Governor for six year terms. It is composed of 10 physicians, two dentists, and two pharmacists. Officers are elected every two years. The Board will be expanded to 15 members soon to include a psychiatrist as a regular member.



heart page

TOXICITY OF QUINIDINE

Jackson W. Landham, Jr., M.D., *Griffin*

SEVERE TOXICITY FROM quinidine occurs often enough for us to realize that its use is a calculated risk.

The manifestations of fever, rash, thrombocytopenia, purpura, or hemolysis need only be mentioned since they rarely occur.

The mild toxic symptoms include blurred vision, transient deafness, anorexia, nausea, weakness, vertigo, tinnitus, slight diarrhea, and headache.

Evidences of moderate toxicity are vomiting, diarrhea, rare to occasional premature ventricular contractions, and increase in the width of the QRS complexes more than 25 per cent but less than 50 per cent of the control value.

Marked toxicity may be indicated by one or more extrasystoles every six beats, ventricular tachycardia, ventricular fibrillation, complete AV block, a QRS duration 50 per cent greater than the QRS duration prior to quinidine.

Hypotension does not occur so often with oral administration of quinidine but the physician must be very alert to this possibility with parenteral quinidine therapy. A fall in the diastolic pressure of 20 mm. of mercury or more may be very serious. There is evidence to indicate that the catastrophic changes such as ventricular fibrillation are prone to occur

when the blood pressure drops and myocardial circulation is further impaired.

The serum concentration of quinidine varies strikingly in different individuals receiving the same dose of the drug. For example, on a daily dose of 3 gms. of quinidine per day, the serum concentration of different subjects has been found to vary from 3 mcgs. per milliliter to 16 mcgs. per milliliter. The toxicity for a given patient is related to the serum concentration of quinidine rather than to the dose of quinidine administered. Therefore, ideally, quinidine dosage should be controlled by means of serum concentration determinations along with electrocardiographic and clinical evaluation. Important myocardial toxicity does not occur with a serum concentration of quinidine of less than 3 mcgs. per milliliter. With serum values of three to 6 mcgs. per milliliter, such myocardial toxicity occurrence is between one and two per cent. With serum values of six to 8 mcgs. per milliliter, this toxicity is about 12 per cent. With values of eight to 10 mcgs. per milliliter, the toxicity is 30 per cent and with values of 12 and 13 mcgs. per milliliter, the toxicity is 45 per cent. With serum concentration of quinidine over 14 mcgs. per milliliter, serious myocardial toxicity occurs in about 65 per cent of the subjects.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Just as the dose and the serum concentration of quinidine do not correlate well, the EKG effects and the serum concentration of quinidine do not correspond closely. The EKG may and should be used to indicate quinidine effect. However, the EKG cannot be used to indicate the serum concentration of quinidine, which is a key factor in toxicity.

Serum concentration alone is not the only factor influencing toxicity. The state of the heart, the severity of failure, the degree of digitalis saturation, the state of electrolyte balance, and the amount of nervous tension of the patient effect the success of quinidine treatment and also the toxicity of quinidine therapy.

Many of us utilize quinidine in our practice when laboratory facilities for determining the serum quinidine concentration are not available. And, of course, we may use quinidine in relatively small doses without checking the serum concentration even when such facilities are available. Experience has shown us that with small doses we rarely run into serious trouble.

When we must use larger doses of quinidine, such as in the attempt to convert atrial fibrillation to sinus rhythm, it is best to hospitalize the patient. In this instance, if conversion does occur, it will usually

occur with serum concentrations of quinidine of 8 mcgs. per milliliter or less. However, as noted above, myocardial toxicity increases rapidly when the level of 8 mcgs. per milliliter is exceeded. A serum concentration of 5 mcgs. per milliliter will usually prevent relapse and this level can usually be achieved with a dose of 0.4 gms. of Quinidine Sulfate® four times a day. In patients requiring less than 3 gms. of quinidine per day for conversion, less than 10 per cent will relapse on 0.4 gms. of quinidine four times a day, a dose which can be tolerated by 90 per cent of the patients without serious toxic effects. If a patient does not convert on a dose of 3 gms. per day, the problem should be carefully evaluated before going beyond this dose.

In discussing the toxicity of quinidine, the incidence of emboli is considered since this complication occasionally occurs when the patient reverts from fibrillation to sinus rhythm or if subsequent relapse occurs. Anticoagulants have been used to reduce this hazard.

Even without signs or symptoms of myocardial toxicity, when blood concentration levels of quinidine are available and are high, the wisdom of further quinidine administration should be questioned. When marked myocardial toxicity is noted clinically or by the electrocardiogram, quinidine should be stopped.

THE PAST AND THE PRESENT



NEW GP PREXY—Ben K. Looper, Canton, left, outgoing president of the Georgia Academy of General Practice, shows a poster summarizing his President's Report to the new GAGP President, Joseph B. Mercer, of Brunswick. The change in officers took place at the Academy's 12th Annual Session in October at the Dinkler Plaza Hotel, Atlanta. Other new officers elected for 1960-1961 include Charles E. McArthur, Cordele, president-elect; W. Frank McKemie, Albany, vice president; M. F. Simmons, Decatur, secretary-treasurer; Albert Morris, Fairburn, chairman of the Board of Directors; R. D. Walter, Calhoun and Robert Huie, Atlanta, delegates to AAGP, and Charles Green, Waynesboro, George Green, Sparta, J. Hubert Milford, Hartwell and William Arwood, Pelham, directors.



mental health page

THE PSYCHOPATH: AN OBSERVATION ON ETIOLOGY

Paul L. Schroeder, M.D., *Atlanta*

EVERY PHYSICIAN, regardless of the nature of his practice, encounters from time to time a patient whom he classifies as a psychopath. In so doing, he has expressed in one word the idea of hopelessness, opprobrium, and mystery.

The mystery has to do with the reason for the character disorder. A variety of causes has been assigned. Historically, it has shifted over the years, ranging from constitutional or inbred inferiority and on toward mental deformity and faulty emotional development. It has long been agreed that there is neither a lack of intelligence nor is there a mental disease present.

Some physicians adhere to the belief that an organic defect is present from which the patient cannot recover. For example, they believe nearly all persons who commit crime are psychopaths. They overlook the fact that criminality of long standing ends in middle age. Except for crimes of fraud, sex, and murder, crime can be said to end at 40. Prison records support this view.

The modern view holds that his psychopathology is a learned condition. William Menninger states, "It is our best psychiatric judgment that the anti-social individual, the so-called 'psychopath,' is maladjusted as the result of mismanaged babyhood and childhood. Gross defects in character are expressions of pathological home life; erotic affection from

parents whose attitudes alternate between over-severity and overindulgence; the lack of correction of, or indifference to misbehavior; the loss of one or both parents by death, separation, or divorce, and the absence of a secure, continuous source of affection."

The condition appears to exist as an acquired behavior of some persons in all walks of life, ranging from the rich to the poor and in all levels in between. It seems not to be related to general or religious education. It appears to have developed as one of the reactions of children to a disturbed parent-child relationship and it has its beginning in early infancy, progressing throughout childhood.

We believe the psychopath is a person who has learned that his every wish, or nearly every wish, will be granted by his parents, or others, if he persists in his demands. As he grows older, he learns how to become more and more persuasive, resorting in time to threats of violence. Ultimately, these may be carried out even against the ones who love him most.

It has been said that these parents love their children too much to be able to say "no" to them, or having said "no," to stick to their decision. Too often they don't really mean "no" and give in to the demands of their children in order to have "peace in the family." This, we believe, is the heart of the

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

problem. It is this inability or unwillingness to remain steadfast that is the basic factor in the development of the psychopath. Other types of reactions may also develop.

These parents are unable to deny the child his wish, due to their own unwillingness to give him even temporary displeasure or pain, and try to make up to him for their usually mistaken belief that they have failed him. They seem to want to gratify his every wish to prove their love. In so doing, they overlook the effect this has on the child's personality growth and development.

What effect this has seems clearly to be a prolongation of the weakness all infants experience at birth. They, therefore, cannot grow in their own feeling of strength. They do not develop a sense of their

responsibility toward other persons and their property. Hence, they retain a low tolerance to stress and do not learn how to deal with their normal and increasing frustrations. It is because the psychopath seems primarily inconsiderate of others that the term has long been used as an opprobrium. It is because he seems never to learn by experience, that there is so much hopelessness over him. And it is because his motivation is rarely understood, that he seems such a mystery.

Until these ideas change, little can be done to help the psychopathic personality. When his condition is studied and dealt with as learned or acquired behavior, it sometimes becomes possible for him to change. Then he may be able to unlearn what he feels about himself and relearn and discover that he is not completely dependent on others; he can still develop a sense of his responsibility toward others and deal effectively with most of his frustrations.

DR. C. A. SMITH HEADS C.D.C.

DR. CLARENCE A. SMITH, deputy chief of the Communicable Disease Center, U. S. Public Health Service, Atlanta, became chief of C.D.C. effective July 1. He succeeds Dr. Robert J. Anderson who has been appointed deputy chief of the Bureau of State Services.

Dr. Smith has spent his entire professional career in the Public Health Service. He has served in medical

posts throughout the United States and was chief of the Public Health Service's Venereal Disease Control Division in Washington just prior to his appointment to C.D.C. in 1957.

Dr. Smith is a native of Gambier, Ohio and a graduate of the University of Colorado Medical School. He holds a master's degree from Johns Hopkins School of Hygiene and Public Health.

LAW ON MEDICAL CARE FOR AGED PRAISED

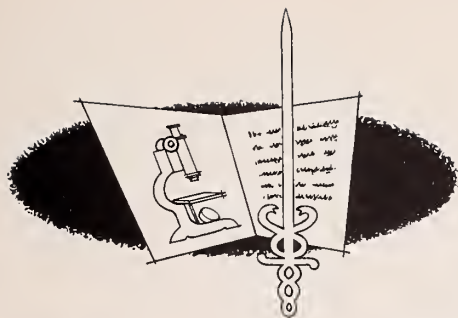
FRANK S. GRONER, president of the American Hospital Association, and Dr. E. Vincent Askey, president of the American Medical Association, recently praised the law on medical care for the aged passed by the recent Congress as "a distinct step forward in meeting the need of those older citizens who are unable to finance their own medical and hospital expenses."

Representatives of allied hospital associations met recently at the American Hospital Association headquarters to discuss methods by which state legislatures and appropriate departments of state government can expedite the activation of the new law and its implementation.

Mr. Groner said, "I hope this meeting will provide the information on which state hospital associations can

move ahead in developing plans to stimulate action by state governments for the improvement of health care for the aged. We feel that this bill provides a mechanism through which the financial problems of hospitals can be eased, for implementation of the new law by the states will result in improved financing of the care rendered by hospitals."

Dr. Askey said the American Medical Association held a similar meeting of AMA representatives from all over the country in late November. He added, "We strongly supported the Kerr-Mills Amendment to the Social Security law providing for this grant-in-aid medical care program for needy and near-needy older persons, and we intend to take every possible action to see that the law is implemented quickly and effectively."



cancer page

A PORPHYRINIC COMPOUND AND THIO-TEPA IN THE TREATMENT OF ADVANCED CANCERS

Enoch Callaway, M.D., *LaGrange*

DURING THE PAST three years at the West Georgia Cancer Clinic we have treated, excluding leukemia and lymphomas, a total of 95 cancer patients with chemotherapeutic agents. All had far advanced disease and the usual forms of treatment had already proven ineffective or had been exhausted.

The drugs used were phyltone* (etioporphyrin, Type III, occurring as metal free potassium salts of porphyrinic compounds) and thio-tepa (triethylene-thiophosphoramide), a well-known alkalating agent. Some of the patients were treated first with one drug, and when this drug ceased to have any further effect, they were shifted to the other. By doing this, it was noted that when the patients who had been given phyltone were shifted back to thio-tepa, the thio-tepa became again effective and its action was considerably enhanced in many instances. Therefore, it was determined to use the two drugs at the same time. *The dosages:* phyltone—two one-half gram capsules daily, one before breakfast, the other at bed time, both at least one hour from any food; thio-tepa—15 mg. dissolved in 1.5 cc. of distilled water and given intramuscularly; blood counts made weekly

and thio-tepa discontinued if WBC below 4,000.

General Results

Cancers showing practically no response: (1) squamous carcinoma of the lip, mouth, and skin; (2) adenocarcinoma of the pancreas and colon; (3) osteogenic sarcoma; (4) metastatic adenocarcinoma, and (5) metastatic anaplastic carcinoma of unknown origin.

Slight response: (1) squamous and adenocarcinoma of the lung; (2) malignant melanoma, and (3) clear cell carcinoma of the kidney.

Varying from none to complete regression: (1) squamous carcinoma of the cervix; (2) adenocarcinoma of the uterus, stomach, and breast; (3) medullary carcinoma of the breast; (4) papillary cystadenocarcinoma of the ovary; (5) leiomyosarcoma of the gastrointestinal tract; (6) carcinoma of the prostate, and (7) carcinoma metastasizing to bone from unknown origin.

Seventeen patients were treated with phyltone alone, with regression noted in eight; 29 patients were treated with thio-tepa alone, with regression noted in 16, and 49 patients were treated with a combination of both drugs, with regression in 24.

*Phyltone furnished by Texophyl Corporation, Boling, Texas.
*Thio-tepa furnished by Lederle Laboratories, American Cynamid Company, New York, N. Y.

Approved by Professional Education Committee, Georgia Division, ACS

A more important fact, however, is that the patients who are living at the present time, and have lived over a long period of time, have been treated by the combined method.

Remarks

The last point above is doubtless due in part to the fact that the combined medication proved much less toxic than the thio-tepa alone, and it was less frequently necessary to discontinue therapy. The phyltone apparently served to reestablish the blood picture and to keep it near normal. Thus, this ther-

apy can usually be continued with minimum periods of interruption.

Complete clinical work on these cases has been recorded, and will be tabulated more fully, with perhaps others, for publication at a later date.

The use of chemotherapeutic agents in cancer is entirely *too* new to make any *definite* statements about either the proper application of this method or its ultimate efficiency. However, the adequacy of chemotherapeutic methods is such that no patient should be relegated to the class of hopeless and untreatable until these agents have been tried and exhausted for each patient.

LOCAL HOSPITAL WINS PRAISE

NOT LONG AGO an article appeared in a newspaper about a Philadelphia pharmaceutical company choosing Ware County's Memorial Hospital for a film on the latest hospital techniques.

The story has been passed on to other newspapers. As a result the local hospital has received wide and very favorable publicity.

A few days ago, for example, the *Atlanta Journal's* "Piney Woods Pete," best known for his razor-sharp political comments, allowed as how he was "right proud" to read that the Waycross hospital would be viewed by people all over the country "because it is full of new gadgets that every hospital should have."

Journal-Herald readers will recall that the story said the 30-minute color film is to be shown to medical and hospital personnel and others throughout the nation.

Certainly, as Pete noted, Waycross and all Georgians have a right to be proud of a hospital that was selected as a model medical center.

Pete said in the *Journal* that he just hoped, after reading about automation at our Memorial Hospital, that "they won't be able to replace them pretty student nurses with machines. . . ."

Our answer to that one is that Memorial Hospital has its share of pretty nurses to match its jet-age equipment and techniques. They're doing a good job, too.

This, in fact, is a good opportunity to commend the administration, medical staff, and personnel of Memorial Hospital for the outstanding service being rendered to the people of our community and area.

—*Journal-Herald, Waycross*

ANNOUNCEMENT FOR GENERAL PRACTITIONERS AND INTERNISTS

APPLICATIONS FOR CHARTER MEMBERSHIP in the American Society of Diagnostic Radiology are now being received. Membership is open to GENERAL PRACTITIONERS and INTERNISTS who do or may desire to do some types of Diagnostic Radiology in their offices.

For further information please write:

Louis Shattuck Baer, M.D., F.A.C.P.
411 Primrose Road
Burlingame, California



physician's bookshelf

BOOKS RECEIVED

Walstenholme, G.E.W., O.B.E., M.A., M.D., M.R.C.P. and O'Connor, Cecilia M., B.Sc., CIBA FOUNDATION COLLOQUIA ON ENDOCRINOLOGY, VOL. 13, Little, Brown and Co., Boston, Mass., 1960, 336 pp., \$9.50.

Artz, Curtis P., M.D., F.A.C.S. and Hardy, James D., M.D., F.A.C.S., COMPLICATIONS IN SURGERY AND THEIR MANAGEMENT, W. B. Saunders Co., Philadelphia, Pa., 1960, 1,075 pp., \$23.00.

Walstenholme, G.E.W., O.B.E., M.A., M.D., M.R.C.P. and O'Connor, Cecilia M., B.Sc., CIBA FOUNDATION SYMPOSIUM ON CONGENITAL MALFORMATIONS, Little, Brown and Co., Boston, Mass., 1960, 308 pp., \$9.00.

Committee on Trauma, American College of Surgeons, THE MANAGEMENT OF FRACTURES AND SOFT TISSUE INJURIES, W. B. Saunders Co., Philadelphia, Pa., 1960, 372 pp., \$5.00.

Stanley-Jones, D. and K., THE KYBERNETICS OF NATURAL SYSTEMS, Pergamon Press, New York, N. Y., 1960, 145 pp., \$6.50.

Garland, Joseph, M.D., THE PHYSICIAN AND HIS PRACTICE, Little, Brown and Co., Boston, Mass., 1960, 270 pp.

Felson, Benjamin, M.D., FUNDAMENTALS OF CHEST ROENTGENOLOGY, W. B. Saunders Co., Philadelphia, Pa., 1960, 301 pp., \$10.00.

REVIEWS

Levine, Harold D., M.D., CARDIAC EMERGENCIES, Landsberger Medical Books, Inc., New York, N. Y., 1960, 381 pp., \$12.00.

FREQUENTLY A PATIENT presenting as a cardiac emergency has a simple problem which may or may not be cardiac. With this in mind the author takes the liberty of touching on other disorders which may present as cardiac emergencies, a sort of differential diagnosis and in no way does this lessen his presentation of the serious cardiac problems which may come under the urgent observation of a physician.

For quick reference, the chapters are divided into short sections of related disease states or symptom complexes. This is not confusing and in this type of book

where treatment is stressed it is helpful to the physician desiring a quick but thorough aid. The section on arrhythmias seems excellent to me, while the chapter on electrolytes seems a bit long.

In the author's thoroughness, he presents all possible therapies, which may be confusing to a young reader. However, he does indicate his own preference and good reasons for such preference. One important feature is the optimism imparted by this volume which is so valuable to the physician handling cardiac problems and to the patient who has them.

T. Sterling Claiborne, M.D.

Walstenholme, G.E.W., O.B.E., M.R.C.P. and O'Connor, Maeve, B.A., CELLULAR ASPECTS OF IMMUNITY, Ciba Foundation Symposium, Little, Brown and Co., Boston, Mass., 1960, 495 pp., \$10.50.

FOR THOSE OF US who may have thought that antibodies and antigens have a simple relationship, one with the other, this symposium will provide a rude awakening. Indeed, unless the reader is already awake and prepared to approach this volume with a clear head and a minimum of distractions, he will find himself overwhelmed. The fact remains, however, that collected herein are the work and distillation of thought of some of science's most brilliant minds turned toward a subject, which as it unfolds, promises to be the basis of understanding such problems as the collagen diseases and transplantation of organs, to name just two.

The 1960 Nobel prize winning work of Professor Medawar and Sir MacFarlane Burnet on immune tolerance of homografts is a notable feature, but other contributors present work of equal caliber, or nearly so.

This volume will be of little help to the clinician in his practice; it is not to be read hurriedly or as light bedtime fare. It will be immensely rewarding to the medical scientist—regardless of specialization—who might wish to broaden his basic understanding of these areas and the exciting new concepts that are developing.

Thomas F. Sellers, Jr., M.D.

Douthwaite, Arthur H., M.D., F.R.C.P., FRENCH'S INDEX OF DIFFERENTIAL DIAGNOSIS, The Williams and Wilkins Co., Baltimore, Md., 1960, 1111 pp., \$24.00.

THIS BOOK IS NO dish of tea to this reviewer—although the buyers of seven previous editions must have felt

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

differently. The preface to the first edition (1912) said that "it covers the whole ground of medicine, surgery, gynecology, ophthalmology, dermatology, and neurology," and the eighth version is no less ambitious. This is an important task, of course, even if pathology, treatment and prognosis are omitted, as they are. The contents are arranged in the manner of a seed catalogue, the items ranging from "Accoucheur's hand" to "Weight, loss of," nearly 1,000 pages later.

In order to test their worth, the reviewer looked for information concerning cases admitted to his own hospital service that very morning. The first patient was a young man with progressive muscular dystrophy but the reader was expected to distinguish it from poliomyelitis, amyotrophic lateral sclerosis, syphilitic pachymeningitis, and physical signs. The second patient was a diabetic with the nephrotic syndrome, and a classification of the important causes of albuminuria listed acute tubular necrosis, calculi, renal tumors, cardiac failure, hypertension, subarachnoid hemorrhage, cantharides poisoning, sclerosing solution in the treatment of varicose veins, leukemia, and scurvy. The third patient had gall stones, but a description of the van den Bergh test did not even mention glucuronic acid.

The other sections were not uniformly bad but this is manifestly no way to learn medicine. A huge cross-index and many illustrations add to the weight of the book and the hand-colored drawings give it a quaint Victorian appearance.

Thomas Findley, M.D.

Rosenstock, Irvin M.; Hochbaum, Godfrey M., and Leventhal, Howard, **THE IMPACT OF ASIAN INFLUENZA ON COMMUNITY LIFE**, Public Health Service Publication No. 766, U.S. Government Printing Office, Washington, D. C., 1960, 98 pp.

THIS monograph describes a study of Asian influenza, as it affected five selected cities, and is concerned with its impact on five areas: (1) community planning and facilities, (2) sero epidemiology, (3) the general population, (4) physicians, nurses, and pharmacists, and (5) industry and hospitals.

This is not so much a study of influenza as it is of communities under stress and as such, several attitudes or patterns of behavior emerge. (1) Few people worried about the epidemic except health officials and community agency personnel. (2) Local medical societies were more concerned about individuals than about the community. These organizations generally failed to exert effective leadership and thereby crippled what programs were undertaken. (3) Panic on part of the population was more feared than the epidemic itself. (4) There was frightening inertia and "let George do it" attitude, which seems to characterize all Americans these days, no matter what the threat.

This monograph reports some attitudes of implied community criticism of the medical profession. Whether these attitudes were just or not, it is clear that here the medical societies failed in their public relations, an all too common event. A perusal, particularly of the first chapter, might be worthwhile for public health and medical society officials.

Thomas F. Sellers, Jr., M.D.

Johnstone, Rutherford T., M.D. and Miller, Seward, E. M.D., **OCCUPATIONAL DISEASES AND INDUSTRIAL MEDICINE**, W. B. Saunders Co., Philadelphia, Pa., 1960, 482 pp., \$12.00.

THE ESSENCE OF THIS excellent text is that the physician in industry must be a good clinician, first and foremost. Long regarded as a refuge for the incompetent and insecure, industrial medicine is acquiring stature and recognition as a specialty in which additional skills are added to general medical ability.

In the first half of this well organized book, the authors discuss the scope and elements of industrial practise: the occupational health team, industrial medicine and workmen's compensation insurance, the placement of the handicapped and the detective elements in the diagnosis of occupational disease, and the matching of clinical symptoms with defective toxic agents.

In part two, a scholarly, but unstuffy, presentation is made of disease entities created by exposure to poisonous elements in industry: the noxious gases, the aliphatic and aromatic hydrocarbons, the pneumoconiosis, the metallic poisons with emphasis on those which may produce cancer, the synthetic resins, propellant fuels, pesticides, and ionizing break down products of radiation. The clinical and pathological descriptions of the pneumoconioses are particularly readable.

This book is a welcome addition to the library of any physician and surgeon who deals with the workers in industry.

A. A. Weinstein, M.D.

Fischer, Carl C., M.D., **THE ROLE OF THE PHYSICIAN IN ENVIRONMENTAL PEDIATRICS**, Landsberger Medical Books, Inc., New York, N. Y., 1960, 122 pp., \$5.50.

PHYSICIANS WHO HAVE had much experience in participating in the solutions of certain socio-pediatric problems will recognize the real contributions this book makes.

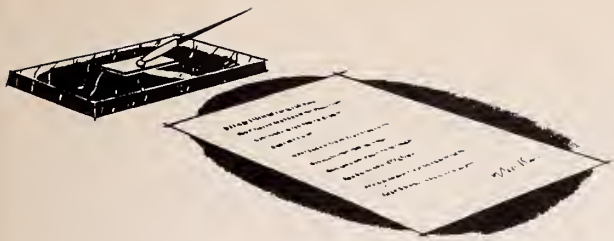
Study of the book will inspire the young clinician to familiarize himself with the problems of adoptions, school health programs, and, particularly, the problems of the adolescent patient.

Preston D. Ellington, M.D.

ATTENTION PHYSICIANS FILING MEDICARE CLAIMS Consult MEDICARE DIRECTIVE XII for help on completing Medicare claim forms.

A directive has been mailed to all physicians. If you did not receive this directive write:

**Medical Association of Georgia
Medicare Department
938 Peachtree Street, N.E.
Atlanta 9, Georgia**



Moretz, William H., M.D., Medical College of Georgia, Augusta, Georgia, "Surgical Monogement of Chronic Arteriol Insufficiency of the Lower Extremities," J. Internat. Coll. Surgeons 34:169-178 (Aug) 1960.

The relative value of direct vessel surgery, sympathectomy, and amputations are discussed as indicated by a study of 119 patients with chronic arterial insufficiency of the lower extremities. The indications and contraindications for each form of treatment are given. The results obtained by endarterectomy are compared with those obtained by using teflon prostheses and by lumbar sympathectomy. In spite of the author's preference for direct vessel surgery, this form of therapy was feasible in only 25 per cent of the patients. Sympathectomy was the primary treatment in 21 per cent, and 50 per cent required primary amputation. Whereas the results of direct vessel surgery are excellent in aorto-iliac occlusive disease, one-third of the direct vessel surgery procedures in the femoropopliteal group which were early successes, subsequently re-occluded.

It is emphasized that longer periods of observation will be required before any final conclusions can be reached concerning the relative merits of endarterectomy, artery, replacement, and sympathectomy for occlusive arterial disease of the extremities.

Koufman, James A., M.D., 950 W. Peachtree Street, N.W., Atlanta 9, Georgia, "Report of a Case of Proved Fulminating Hemophilus Influenzae Pneumonia in an Adult with Recovery," Dis. of the Chest 38:199-201 (Aug), 1960.

This case was presented because it is of more than usual interest for several reasons. It was a case of pneumonia caused by an unusual etiological agent, particularly in an adult. It was extraordinarily extensive and severe. In fact, several experienced observers are of the opinion that it was the most severe case of pneumonia with recovery that they had ever seen. It illustrated several very important practical points in the diagnosis and treatment of pneumonias in general.

(1) Hemophilus influenzae is an unusual cause of pneumonia, particularly in the adult. In fact, in the 20 years prior to 1954, Crowell and Loube found only three case reports in the American literature. Pure cultures of Hemophilus influenzae, type b, from the sputum and the blood at the very onset, and the failure of extensive

studies to reveal any co-existent etiological agent, are substantial proof of its causative role in this case, despite the known peculiarities of the Hemophilus influenzae organism.

(2) This case points out the importance of withholding chemotherapy and antibiotic therapy until cultures can be obtained, because of the resistance of some organisms to usual therapy, and, as in this case, unusual bacteriological agents can be responsible for the pneumonia.

(3) Initial leukopenia followed by leukocytosis is more common in Hemophilus influenzae infections. However, any overwhelming bacterial infection can be ushered in with a marked leukopenia and normal temperature, but this does not necessarily imply that the pneumonia is of viral or rickettsial origin.

(4) This patient developed delirium tremens, a complication that has been seen so frequently in heavy drinkers with pneumonia. This should be anticipated in alcoholics who develop pneumonia and treated vigorously, because delirium tremens can be fatal, even without concomitant disease.

(5) This case illustrated how the febrile period can be prolonged by the administration of antibiotics, particularly in massive doses.

(6) Finally, it served to emphasize the importance of a comprehensive approach to severely ill patients with pneumonia including prompt etiological diagnosis, massive appropriate antibiotic therapy, intensive supportive measures, and prompt management of complications which are so frequent in overwhelming pneumonic infections.

McDonald, Harold P., M.D.; Upchurch, Wilborn E., M.D., and Celaya, Carlos L., M.D., 272 Ivy Street, N.E., Atlanta 3, Georgia, "Correction of Hypospadias," South. M.J. 53:1069-1075 (Sept) 1960.

The authors emphasize the important steps in the correction of this congenital anomaly. They have used steps from two classical procedures advanced in the past for this reconstructive surgery.

Correction of hypospadias should be begun early, preferably by the age of two years. The first stage or correction of the chordee consists of complete elimination of fibrous bands restricting the ventral elongation of the penis. A minimum of six months should elapse before the second stage procedure for the formation of the urethra is attempt-

ed. A modified Duplay technic as well as the Denis Browne technic for repair of hypospadias are both recommended and it is essential that a new urethra be of adequate caliber. Formation of the urethra over a small catheter is recommended and hot tub baths early during the postoperative period encourage rapid healing. Avoidance of suture pressure points and elimination of multiple knots in the subcutaneous tissues by the use of a continuous suture of fine chromic catgut on atraumatic needles are recommended. Care to avoid undue pressure or tension is an essential factor in encouraging primary healing. The use of stilbestrol pre- and postoperatively to eliminate troublesome erections is recommended.

Hock, Charles W., M.D., 1467 Harper Street, Augusta, Georgia, "Combined Oxyphenyclimine-Hydroxyzine Therapy in Gastroenterologic Disorders," Am. J. Gastroenterology 34:293-298 (Sept) 1960.

Effective use of combined oxyphenyclimine-hydroxyzine (Enarax®) in 88 per cent of 102 patients with various gastrointestinal disorders is reported. Patients included 45 with functional bowel distress; 22 with duodenal ulcer; nine with postcholecystectomy or post-gastrectomy syndromes; five with ulcerative colitis; two each with gastritis, duodenitis, diverticulitis, and pyloric ulcer, and 13 with various other conditions.

The majority of patients had multiple gastrointestinal symptoms in addition to anxiety, tension, apprehension, insomnia, or depression. For maximal therapeutic effectiveness devoid of side effects, one-half Enarax® tablet q.i.d. became the daily dosage upon which patients were stabilized. Adjunctive therapy included special diets, antacids, laxatives, antidiarrheal agents, appetite depressants, sulfonamides, and nitroglycerin.

Complete or almost complete control of symptoms was achieved with Enarax® in 70 patients, while an additional 18 experienced amelioration of symptoms. Therapy was effective in 38 of the 45 patients with functional bowel distress and in 21 of the 22 with duodenal ulcer. Treatment was not effective in 14 patients with tabes dorsalis, ileitis, pancreatitis, and cholelithiasis. Minor side effects, related to the initially high dosage with which therapy was initiated, occurred in 43 patients and included dryness of the mouth, blurring of vision, drowsiness, and urinary hesitancy.



the association

DEATHS

BETHEL BRYANT CHANDLER, 92, of Lula, died October 19 at a private nursing home.

Having practiced medicine for more than 50 years, Dr. Chandler had been a physician in Hall County since 1931, and prior to that time, had practiced in Athens.

He was a Shriner, a member of the Hall County Medical Society, Medical Association of Georgia, the American Medical Association, and the Lula Baptist Church.

Survivors include his wife, Mrs. Lola Chandler, Lula; one son, Dr. Howe L. Chandler, Athens; one brother, Dr. Ed Chandler, Maysville; one sister, Mrs. H. W. Meadows, Toccoa; three grandchildren, and seven great-grandchildren.

WILLIAM C. COOK, of Columbus, died October 13 at the age of 54 after a lengthy illness.

Dr. Cook, a native of Hamilton, was the son of the late Cecelian Hubert and Mary Copeland Cook, and had lived in Columbus for 26 years.

He attended the public schools of Hamilton, received his BS degree from Mercer University, his MD degree from Emory University School of Medicine, and his MA degree from the University of Cincinnati.

Dr. Cook started the Kiwanis Nutrition Clinic at the Goodwill Center and was the recipient of the first award by the Columbus Junior Chamber of Commerce for the "Outstanding Young Man of the Year" in 1936.

He was past president of the Muscogee County Medical Society, Columbus Executives Club, and the Columbus Kiawanis Club. He was also a member of the American Academy of Pediatrics, the Georgia Pediatrics Society, the Medical Association of Georgia, Alpha Kappa Kappa medical fraternity, Kappa Alpha social fraternity, and the Candun Club of Columbus.

Dr. Cook was elected to the board of directors of the Columbus School for Speech Correction in March, 1955.

Survivors include his wife, Mrs. Lucille Van Meter Cook, Columbus; two sisters, Mrs. J. T. Peavy, Hamilton, and Mrs. Bostick Curry, Pelham; a brother, Hatch Cook, Atlanta, and several nieces and nephews.

GEORGE LEE ECHOLS, a veteran Georgia physician, died October 23 at the age of 85 at a hospital in Milledgeville, his home town.

Dr. Echols was graduated from the University of Georgia in 1903 and from the Atlanta College of Physicians and Surgeons (now Emory University) in 1908. Later he attended Harvard Medical School.

As a member of the medical staff of the Milledgeville State Hospital for 44 years, he retired in 1954.

Survivors include his wife, a son, two daughters, two brothers, a sister, and six grandchildren.

CLAYBORNE ANDERSON HARRIS, of The Rock, died October 17 at the age of 83 at his home.

A native of Forsyth County, Dr. Harris received his MD degree from Emory University School of Medicine in 1909. Before entering medical school, he attended the Southern College of Pharmacy. Upon graduation from medical school, he began his life work as a general practitioner at The Rock, retiring in 1951 because of ill health.

In 1955, a doctor's appreciation day was held for Dr. Harris when families all throughout his area showed their appreciation for the many services he performed.

Dr. Harris held a 50-year pin from the Medical Association of Georgia, was a life member of the American Medical Association, and had served as president of the Upson County Medical Society. He was a member of The Rock Baptist Church.

Survivors include his wife, Mrs. Parilee Heard Harris; two daughters, Mrs. Herman Barker and Miss Marie Harris, The Rock; three sons, Clay, Cecil, and Heard Harris, all of The Rock; two sisters, Mrs. Roselee Moore, Cumming, and Mrs. W. W. Heard, Atlanta, and one grandson.

THOMAS CORNELIUS JEFFORD, 91, one of Sylvester's most prominent businessmen and a retired physician, died October 16 after an extended illness.

A native of Ware County, Dr. Jefford was the son of the late Harmon F. and Mary McQuaig Jefford.

He graduated from the Atlanta College of Physicians and Surgeons and in 1894, he graduated from the Atlanta Dental College. Soon after that, he made his home in Sylvester where he practiced medicine and dentistry. He later retired from his profession to enter the field of business.

Dr. Jefford was a member of the board of stewards of Pinson Memorial Methodist Church and was chairman of the board of directors of the Sylvester Banking Company. He was a member of Worth Lodge 194, F & AM, the Worth County Hospital Authority, and

was a past president of the Sylvester Kiwanis Club.

Survivors include three sisters, Miss Susan Jefford and Mrs. John Lee, Waresboro, and Mrs. Lewis Herrin, Sr., Pooler, and a number of nieces and nephews.

JOHN TINKHAM MANTER, 50, assistant professor of neurology and micro-anatomy at the Medical College of Georgia, Augusta, died November 5 at an infirmary in Augusta.

A native of Anson, Me., Dr. Manter had lived in Augusta since 1945 and was a member of the Reid Memorial Presbyterian Church.

Dr. Manter received his A.B. degree from Bates College in Maine, his Ph.D. degree from Columbia University, and his M.D. degree from the Medical College of Georgia.

Professional membership included the American Medical Association, Medical Association of Georgia, Richmond County Medical Society, American Association of Physical Anthropologists, American Association of Anatomists, and Southeastern Electroencephalography Society.

Surviving are his wife, Mrs. Florence Ogden Manter; a son, John Ogden Manter; two daughters, Carol O. Manter and Mary A. Manter, all of Augusta; a brother, Dr. Harold Manter, of the University of Nebraska, and a sister, Mrs. Keturah Taylor, Dover, N. H.

W. EDGAR McCURRY, of Hartwell, died at the age of 83 in a Macon hospital after an extended illness.

A native of Fair Play, S. C., Dr. McCurry was a graduate of the University of Georgia, where he was a member of Delta Tau Delta fraternity. He also was graduated from the University of Maryland School of Medicine and did postgraduate work in internal medicine at the University of Pennsylvania.

During World War I, he served with the medical corps and he was a member of the Medical Association of Georgia and the First Methodist Church in Hartwell.

Surviving him are two daughters, Miss Myra McCurry and Mrs. William M. Hammond, both of Atlanta, and two grandchildren.

Y. HARRIS YARBROUGH, serving his 55th year as a member of the staff of Milledgeville State Hospital, died October 24 at the age of 78 at an Atlanta hospital.

Dr. Yarbrough, a native of Newnan, joined the staff of the state mental institution in 1906, following his graduation from the Emory University School of Medicine in 1905.

He had served as superintendent of the state hospital from 1943 to 1948 and was previously assistant superintendent.

A life member of the American Medical Association, he was also a member of the Baldwin County Medical Society, Sixth District Medical Society, Medical Association of Georgia, American Psychiatric Association, and was a fellow in the American College of Psychiatrists.

Dr. Yarbrough had served as psychiatric consultant at various times to the federal penitentiary in Atlanta and to hospitals in Macon and Augusta. He was also

a lecturer at the Medical College of Georgia in Augusta.

Dr. Yarbrough is survived by his wife, Mrs. Y. Harris Yarbrough of Milledgeville.

PERSONALS

First District

LAWRENCE LEE, JR., Savannah, has been named director of the Chatham Clinic for Alcoholism, succeeding **ANNE McHENRY HOPKINS**, Savannah, director for several years, who will remain on the clinic staff.

ALBERT J. KELLEY, Savannah, chairman of the Health and Hospital Planning Council, recently met with state health officials to review the psychiatric care facilities in Savannah.

CURTIS HAMES, of Claxton, recently spoke at the 12th Annual Meeting of the G.A.G.P. in Atlanta, on the problem of being overweight as a greater contributing factor than cholesterol in hardening of the arteries. Dr. Hames also spoke to the annual Southeastern Regional Meeting of the American College of Physicians in Ponte Vedra Beach, Fla., in October.

During the annual meeting of the G.A.G.P.'s in Atlanta recently, **ELLISON R. COOK, III**, Savannah, presented a paper on stroke rehabilitation.

C. G. GREEN, Waynesboro, and **KATRINE HAWKINS**, Sylvania, were among some 300 family physicians that attended the 12th Annual Meeting of the G.A.G.P. in Atlanta in October.

Second District

FRANK E. THOMAS, Albany, recently spoke to the Sylvandale P.T.A. on health and hygiene in connection with school children.

GEORGE R. DILLINGER, of Thomasville was recently guest speaker of the Meigs Kiwanis Club.

Third District

Recently, **JACK C. HUGHSTON**, Columbus, spoke to members of the Morningside P.T.A. in Columbus.

Fourth District

ROBERT L. BENNETT, Warm Springs, recently spoke at the fall convocation at the University of Pittsburgh.

W. P. ELLIS, Pine Mountain's only physician, was featured in the Columbus *Ledger-Enquirer* magazine, having recently observed his 81st birthday.

HILT HAMMETT, JR., LaGrange, recently spoke to the LaGrange Rotary Club at the Colonial Hotel.

Fifth District

SIDNEY OLANSKY, A. GRIGG CHURCHWELL, CARL C. JONES, WILLIAM C. WANSKER, and OLIN SHIVERS, all of Atlanta, and HAMILTON W. McKAY, JR., Chamblee, addressed the 15th annual meeting of the Southeastern Allergy Association, held in Atlanta recently.

R. BRUCE LOGUE, Atlanta, recently attended the meeting of the Washington State Heart Association in Seattle, where he gave a series of three talks and participated in three panel discussions.

Recently the government of France presented the Croix De Merite Combattant French Military Medal, one of the highest and most coveted that government can present, to WINSTON E. BURDINE, Atlanta, for his outstanding work on the "People to People Program." Dr. Burdine also toured Mexico in November under the same program, as guest of the Mexican Government.

WILLIAM A. HOPKINS, JOSEPH C. MASSEE, ROSS McLEAN, and WALTER L. BLOOM, all of Atlanta, recently spoke at the 12th Annual Meeting of the G.A.G.P., held in Atlanta.

DAVID HENRY POER, Atlanta, a past secretary-treasurer of MAG, was elected first vice president-elect at a recent meeting of the American College of Surgeons, held in San Francisco.

JOSEPH S. CRUISE, Atlanta, was elected president of the Georgia Tuberculosis Association at the final session of the group's 47th annual meeting in Savannah.

LESTER PETRIE, Atlanta, spoke to the members of the Georgia Tuberculosis Association in Savannah recently on the new Georgia plan for case detection of TB.

Camera shots of Leopoldville and a 30,000-mile journey from Capetown to Cairo were shown recently by WILLIAM E. MITCHELL, Atlanta, at the Atlanta Art Association. Dr. Mitchell made the shots on a six-week trip in Africa last year.

Sixth District

JOE SAM ROBINSON, Macon, recently participated in a panel discussion on pulmonary tuberculosis at the annual meeting of the G.A.G.P. in Atlanta.

LEONARD CAMPBELL, Bibb County medical examiner, was recently the guest speaker for the Macon Civitan Club.

The Eatonton P.T.A. was recently addressed by CHARLES H. RICHARDSON, of Macon, who spoke on "The Art of Living Well and Long."

THOMAS L. ROSS, JR., Macon, was elected a director of the American Heart Association during the organization's annual meeting in St. Louis recently.

Seventh District

ROBERT P. COGGINS, Marietta, discussed disorders of the heart and circulatory system at a recent meeting of the Rockmart Rotary Club.

CHARLES J. REY, JR., formerly of Macon, has joined the staff of the Austell Hospital in Austell.

RAYMOND CORPE, superintendent of Battey State TB Hospital in Rome, was recently elected president of the Georgia Thoracic Society.

LESTER J. MARTENS, Rome, discussed heart defects and diseases in children at a recent meeting of the Piedmont School P.T.A.

C. VERNON TANNER, Dalton, was recently guest speaker at a meeting of the Civil Defense Nurse Assistants held at the Hamilton Memorial Hospital.

Eighth District

RALPH ROBERTS, of Fitzgerald, was recently elected to the City Board of Education in Fitzgerald.

Ninth District

A. FREDERICK BLOODWORTH, Gainesville, was recently named president-elect of the Georgia Thoracic Society.

Tenth District

D. N. THOMPSON, Elberton, who recently celebrated his 74th birthday, has been given an honorary membership in the G.A.G.P. in recognition of his contributions to the advancement of medicine and surgery in the state.

CORBETT H. THIGPEN, Augusta, recently spoke in Toccoa at the Toccoa High School Auditorium.

SOCIETIES

At a recent meeting of the BALDWIN COUNTY MEDICAL SOCIETY, the following new officers were elected: W. T. Smith, president; H. R. Cary, vice president; E. W. Allen, secretary-treasurer; E. Y. Walker, delegate; M. E. Smith, alternate delegate; Z. L. Burrell, delegate, and J. J. Wood, alternate delegate.

The FULTON COUNTY MEDICAL SOCIETY has announced its approval of the state's proposal for a 500-bed psychiatric hospital in Atlanta.

Recently there was a called meeting of the GEORGIA MEDICAL SOCIETY to vote on proposed changes in the society's constitution and bylaws.

The MUSCOGEE COUNTY MEDICAL SOCIETY was recently host to a meeting of the THIRD DISTRICT MEDICAL SOCIETY. A B. Conger, Ralph Tiller, and Richard A. Dodelin participated in the scientific sessions.

Wentford A. Spears, Warner Robins, was elected president-elect of the PEACH BELT MEDICAL SOCIETY at a recent meeting of the society in Warner Robins. Elected to serve with Dr. Spears were Vernon J. Grantham, Ft. Valley, secretary-treasurer; Eugene Weems, Perry, delegate, and Frank Vinson, Ft. Valley, delegate.

The UPSON COUNTY MEDICAL SOCIETY has

endorsed fluoridation in the public water system of Thomaston.

Free polio shots were donated by the WARE COUNTY MEDICAL SOCIETY and the Waycross Pharmaceutical Association and administered by volunteer registered nurses recently at the Ware County Fair.

At a recent meeting of the THIRD DISTRICT MEDICAL SOCIETY held at the Columbus Country Club, the following officers were elected: Robert H. Vaughan, Columbus, president; Schley Gatewood, Americus, vice president; Robert Collins, Americus, secretary-treasurer; Frank Wilson, Leslie, counselor; Robert Martin, Cuthbert, vice counselor, and George Hutto, Columbus, nominated to the Georgia State Board of Health.

During a recent meeting of the FIFTH DISTRICT MEDICAL SOCIETY, the FULTON COUNTY MEDICAL SOCIETY being hosts, the following new officers were elected: Haywood N. Hill, Atlanta, president; Timothy Harden, Decatur, vice president, and Carl C. Jones, Atlanta, secretary.

EXECUTIVE COMMITTEE OF COUNCIL MEETING MINUTES

A SPECIAL CALLED meeting of the Executive Committee of the Council of the Medical Association of Georgia was called to order by Chairman Milford B. Hatcher at 9:10 A.M., October 23, 1960, in the Dempsey Hotel, Macon, Georgia.

Members of the Executive Committee of Council present included: Milford B. Hatcher, Macon, President; Fred Simonton, Chickamauga, President-Elect; Luther Wolff, Columbus, Immediate Past-President; J. G. McDaniel, Atlanta, Chairman of Council; John T. Mauldin, Atlanta, Secretary, and Virgil Williams, Griffin, Finance Committee Chairman. Also in attendance were J. W. Chambers, LaGrange, MAG Representative on the Governor's Study Committee of Health Care of the Aged, and Messrs. M. D. Krueger and John F. Kiser of the MAG Headquarters Office Staff, Atlanta.

Call of the Meeting

President Hatcher explained that the purpose of this called meeting of the Executive Committee of Council was to discuss plans and provisions for the implementation by the State of Georgia of the recently enacted Old Age Assistance Medical Care Program and the Medical Assistance for the Aged Medical Care Program. He further stated that by discussion of these laws the Executive Committee could best recommend to Council certain policies for the guidance of J. W. Chambers, MAG Representative on the Governor's Study Committee.

Indigent Health Care Programs

Mr. John Kiser gave background data on the Health Care Programs in reviewing the present HIC Law, the Old Age Assistance Law, and the Medical Assistance to the Aged laws.

Governor's Study Committee Report

J. W. Chambers and John T. Mauldin presented a review of the Governor's Study Commission on Health Care of the Aging function and progress to date.

Recommendations

On motion (McDaniel-Simonton) it was voted that the Executive Committee recommends to the Council of the Medical Association the endorsement and support of the Old Age Assistance Program and the Medical Assistance for the Aged Program as provided for in the recently enacted Kerr-Mills Bill.

On motion (McDaniel-Simonton) it was voted that Executive Committee recommends to the Council that the Medical Association of Georgia and allied health care organizations have a definite voice in policies of supervision and administration of

the Old Age Assistance and Medical Assistance for the Aged Health Care Program.

There being no further business the Executive Committee was adjourned at 11:25 A.M.

COUNCIL MEETING MINUTES

A SPECIAL CALLED meeting of the Medical Association Council was called to order by Council Chairman J. G. McDaniel at 11:35 A.M., October 23, 1960, in the Dempsey Hotel, Macon, Georgia.

Council members present at this meeting included: Milford B. Hatcher, Macon, President; Fred Simonton, Chickamauga, President-Elect; Luther Wolff, Columbus, Immediate Past-President; Simone Brocato, Columbus, First Vice President; Braswell E. Collins, Macon, Second Vice-President; Thomas Goodwin, Augusta, Speaker of the House; John T. Mauldin, Atlanta, Secretary; T. A. Peterson, Savannah, Vice-Councilor acting as First District Councilor; George Dillinger, Thomasville, Second District Councilor; W. G. Elliott, Cuthbert, Third District Councilor; Virgil Williams, Griffin, Fourth District Councilor; J. G. McDaniel, Atlanta, Fifth District Councilor and Chairman of Council; George Alexander, Forsyth, Sixth District Councilor; Ralph Fowler, Marietta, Seventh District Councilor; Charles Andrews, Canton, Ninth District Councilor; Addison Simpson, Jr., Washington, Tenth District Councilor; Eustace Allen, Atlanta and J. W. Chambers, LaGrange, AMA-MAG Delegates, and T. A. Sappington, Thomaston. Also present were Messrs. M. D. Krueger and John F. Kiser of the Headquarters Office Staff, Atlanta.

Call of Meeting

President Hatcher stated that this meeting was called to discuss the implementation of Federal legislation known as the Kerr-Mills Bill providing for the consideration of OAA and MAA Health Programs in Georgia. Dr. Hatcher stated that this meeting would be extremely helpful in guidance for the MAG Representative on the Governor's Study Commission on Health Care of the Aged, J. W. Chambers. This Study Committee was created by executive order of the Governor to recommend to the Governor and General Assembly of Georgia proposed legislation to enable Georgia to participate in the provisions of the Kerr-Mills Bill.

Indigent Health Care Programs

Mr. John Kiser, Associate Executive Secretary, reviewed Public Assistance Programs with special emphasis on the recent provisions of the Kerr-Mills Bill providing Old Age Assistance and Medical Assistance for the Aged Health Programs.

Governor's Study Committee Report

J. W. Chambers and John T. Mauldin, members of the Governor's Study Commission on Health Care of the Aged, reported on the function and progress of the Governor's Committee in proposing enabling legislation for Georgia participation in the provisions of the Kerr-Mills Bill; namely OAA and MAA.

MAG Policy

On motion (Collins-Elliott) it was voted that the Council of the Medical Association of Georgia endorses and supports the State of Georgia participation in those provisions of the Kerr-Mills Bill known as Old Age Assistance Health Care and Medical Assistance to the Aged Health Care Programs.

General discussion ensued as to the provisions of the law and implementation through enabling legislation of these programs in Georgia.

On Motion (Hatcher-Elliott) it was voted that the Medical Association of Georgia and allied health care organizations seek to have a definite voice in policies of supervision and administration of the OAA and MAA Health Care Programs in Georgia.

There being no further business the meeting was then adjourned at 3:00 P.M.

**1961 MAG Roster will be sent to all
Active MAG members with January
Journal.**

NEW MEDICAL LICENSES ISSUED

THE FOLLOWING HAVE been licensed in Georgia by reciprocity, effective October 13, 1960:

License No.	Name and Address	
9308	Spencer Delancey Albright, III 3045 Acorn Rd., Augusta	9328 Daniel Rawls Luke 415 Bradford St., Gainesville
9309	Joseph Peter Barreca, Jr. 1059 Warwick Ave., Norfolk 3, Va.	9329 James Aaron Lyons, Jr. c/o Carraway Methodist Hospital, Birmingham, Ala.
9310	Mark Brown Talmadge Memorial Hospital, Augusta	9330 Ross Lewis McLean 3564 Roswell Rd., N.W., Atlanta 5
9311	Richard Mitchell Carter 8B Savannah Terrace Apts., Buena Vista Ave., North Augusta, S. C.	9331 Frank Shipps MacDonell 1727-B N. Decatur Rd., Atlanta 7
9312	Royal Thomas Farrow 2017 Geneva St., Aurora, Colo.	9332 William LeRoy Maden, Jr. 209 Erie Ave., Decatur
9313	Thomas Cantrell Flannigan Meigs	9333 Edward Simpson Miller Battey State Hospital, Rome
9314	James Lee Gardner 2015 S. Second, E #38, Salt Lake City, Utah	9334 Harold Ezra Mitzelfelt c/o Dr. James D. Schuler, Ellijay
9315	Davis Garland Garrett, Jr. 8 Moss Hill Apts., Gainesville	9335 Jack Riley Newman 1060-A Winton Ave., Macon
9316	Clarence Edward Gordon c/o Floyd Hospital, Rome	9336 William Carlton Porch Chatsworth
9317	Edward Mitchell Graves Box 629, Toccoa	9337 Harry Williams Prater, Jr. Jeffersonville
9318	Wayne Van Greenberg Apt. 18-D, Country Club Apts., Augusta	9338 Henri Amin Rathle Theodore, Ala.
9319	Peter Grossgart Medical College of Georgia, Augusta	9339 William Edward Rowe 2500½ E. Third St., Chattanooga, Tenn.
9320	George William Hall Grady Memorial Hospital, Atlanta 3	9340 David Hamilton Smith 101 Baptist Professional Bldg., Atlanta 12
9321	Frederick Ferdinand Hardin 1800 Jefferson Park Ave., Charlottesville, Va.	9341 Donald Charles Stecker 5117-D Minnesota Cir., Plattsburgh AFB, N. Y.
9322	George Irwin Harrison Naval Hospital, Beaufort, S. C.	9342 John Van Duyn, II 1415 3rd Ave., Columbus
9323	Kurt Hasenhuttl 81 Longfellow Ave., Newark 6, N. J.	9343 Robert Irvin Varner Doctors Clinic, Jesup
9324	Durwood Lawrence Kirk 744 McCallie Ave., Chattanooga, Tenn.	9344 Billy Leonard Vaughan Residents Quarters, Talmadge Mem. Hospital, Augusta
9325	Andrew Lee Lawrence, Jr. 2609 Tredway Dr., Macon	9345 Lewis Albert Walker 3658 Fortingale Rd., Chamblee
9326	Charles Frederick Lescher 17 Prescott St., N.E., Atlanta	9345 Richard Storer Ward 80 Irving Place, New York 3, N. Y.
9327	Esten Opland Lindseth Thoracic Surgery Dept., Emory Univ. Clinic, Atlanta 22	9347 Perry Merrill White, Jr. 3338 Tanglewood Dr., Augusta
		9348 Alberto Anibal Zavaleta Lenwood Hospital, Apt. 32 West, Augusta
		9349 Frederick Paul Zuspan Dept. of Obstetrics and Gynecology, Talmadge Mem. Hospital, Augusta

Plan Now to ATTEND the 107th Annual Session of the Medical Association of Georgia

Atlanta Biltmore Hotel

May 7-10, 1961

Atlanta, Georgia

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against cancer quackery

Inspired by model legislation formulated by this committee with the active cooperation of the California Medical Association, California, Kentucky and Nevada recently passed bills providing the first effective means of fighting cancer quackery at its base of operations—in the local community.

To keep both the public and the medical profession informed, the Society has established, in its national office, a central repository of material on new or unproved methods of cancer diagnosis, treatment and cure—a principal source of such information in this country.

The American Cancer Society, in this as in all its efforts, serves both the private citizen and the practicing physician—and is, in turn, served by both.



THE AMERICAN CANCER SOCIETY

GEORGIA DIVISION

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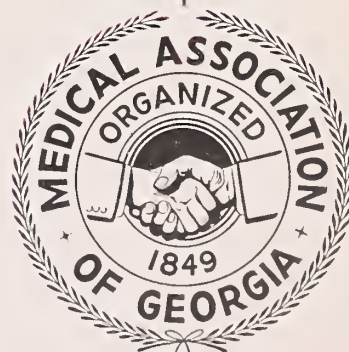
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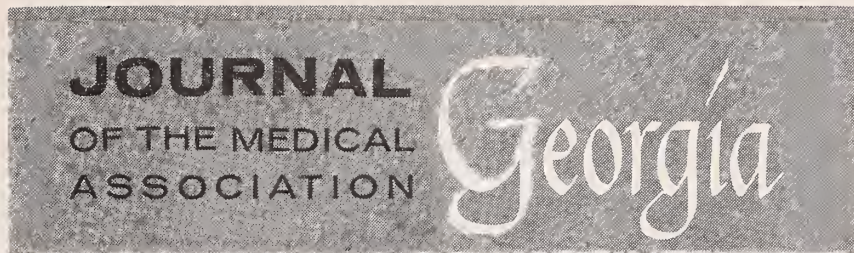
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